

2011

**SENATE
HEALTH CARE**

MINUTES

NORTH CAROLINA GENERAL ASSEMBLY

HEALTH CARE 2011 – 2012 SESSION



Senator Stan Bingham
Co-Chair

Senator Harris Blake
Co-Chair

Senator Louis Pate
Co-Chair



Senator James Forrester



Senator Austin Allran



Senator Robert Atwater



Senator Doug Berger



Senator Debbie Clary



Senator Eleanor Kinnaird



Senator Eric Mansfield



Senator Wesley Meredith



Senator William Purcell



Senator Bill Rabon



Senator Gladys Robinson



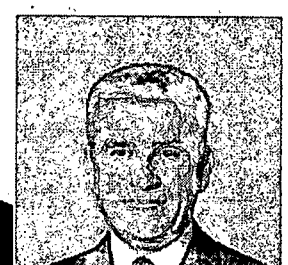
Senator David Rouser



Senator Robert Roucho



Senator Tommy Tucker



Senator Jim Davis

ATTENDANCE

Committee: Senate Health Care Committee

[illegible]

North Carolina General Assembly
Through Senate Committee on
Health Care

Date: 06/22/2011
Time: 11:08
Page: 001 of 004
Leg. Day: H-087/S-087

2011-2012 Biennium

Bill	Introducer	Short Title	Latest Action	In Date	Out Date
H0012=	Cleveland	STOP METHAMPHETAMINE LABS.	*S Pres. To Gov. 6/17/2011	06-13-11	06-14-11
H060=	Pierce	EXTEND HEARING LOSS TASK FORCE.	SR Ch. SL 2011-20	02-24-11	03-16-11
H0160	Dollar	CHECK-OFF DONATION: BREAST CANCER SCREENING.	*S Re-ref Com On Rules and Operations of the Senate	05-02-11	05-18-11
H0218=	Insko	LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.	*S Re-ref Com On Rules and Operations of the Senate	04-07-11	06-08-11
H0397	Lewis	DHHS PENALTIES AND REMEDIES REVISION.-AB	*S Pres. To Gov. 6/17/2011	05-10-11	06-08-11
H0474	Weiss	PROTECT ADULT CARE HOME RESIDENTS.	*SR Ch. SL 2011-99	05-02-11	05-12-11
H0509	Hurley	EXCLUSIONS FROM LICENSURE: HOME SERVICES.	S Pres. To Gov. 6/15/2011	05-02-11	06-08-11
H0590	M. Alexander	AMEND INTERPRETER LAWS/CUED SPEECH.	*S Ref To Com On Health Care	06-08-11	
H0614	Murry	DMA POST PUBLIC NOTICES OF CHANGE ON WEBSITE.	*S Ref To Com On Health Care	04-14-11	
H0622	McCormick	NURSING HOMES/FOOD SERVICES INSPECTIONS.	*S Pres. To Gov. 6/16/2011	06-08-11	06-14-11
\$ H0646	Health and Human	PRISON HOSPITAL COMPLETION.	S Pres. To Gov. 6/16/2011	05-19-11	06-08-11
H0647	Health and Human	DIABETES TASK FORCE.	SR Ch. Res 2011-6	04-27-11	06-08-11
H0677	Lewis	DISCHARGE OF ADULT CARE HOME RESIDENTS.	*S Pres. To Gov. 6/20/2011	06-08-11	06-14-11
H0678	Lewis	PILOT RELEASE OF INMATES TO ADULT CARE HOMES.	*S Pres. To Gov. 6/17/2011	06-08-11	06-14-11
H0792	Folwell	GFELLER-WALLER CONCUSSION AWARENESS ACT.	*SR Ch. SL 2011-147	05-04-11	06-08-11
H0795	Steen	PATIENT ACCESS TO PATHOLOGICAL MATERIALS.	*S Ref To Com On Health Care	05-19-11	
H0808	Burr	REVISE LAWS ON ADULT CARE HOMES.	*S Pres. To Gov. 6/17/2011	05-03-11	06-08-11
H0809	Burr	MODEL HEALTHCARE-ASSOCIATED INFECTIONS LAW.	*S Pres. To Gov. 6/20/2011	06-08-11	06-14-11
H0887	Moffitt	ZONING/TEMP. FAMILY HEALTH CARE STRUCTURES.	*S Re-ref Com On Finance	06-14-11	06-14-11
H0914	Carney	AEDS IN STATE BUILDINGS.	S Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	06-06-11	
S0072	Eleanor Kinnaird	SOCIAL SECURITY INCREASE/MEDICAID ELIG.	S Ref to Health Care. If fav, re-ref to Finance	02-16-11	

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North Carolina General Assembly
Through Senate Committee on
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2011-2012 Biennium

Bill	Introducer	Short Title	Latest Action	In Date	Out Date
S0111=	William R. Purce	DESIGNATE KIDNEY MONTH.	S Ref To Com On Health Care	02-24-11	
1112	William R. Purce	DISAPPROVE PHARMACY BOARD RULE.	S Ref To Com On Health Care	02-24-11	
S0167=	Fletcher L. Hart	ALLOW EXPANSION OF CAPITATED WAIVER.	S Re-ref Com On Mental Health & Youth Services	03-02-11	03-10-11
S0245=	Fletcher L. Hart	MEDICAID BILLING BY LOCAL HEALTH DEPARTMENTS.	*SR Ch. SL 2011-90	03-08-11	03-17-11
S0246=	Fletcher L. Hart	EXPAND PHARMACISTS' IMMUNIZING AUTHORITY.	*S Ref To Com On Health and Human Services	03-08-11	06-08-11
S0248=	Fletcher L. Hart	UPDATE ARCHAIC DISABILITY TERMS.	*SR Ch. SL 2011-29	03-08-11	03-16-11
S0307=	Fletcher L. Hart	SMART CARD BIOMETRICS AGAINST MEDICAID FRAUD.	*SR Ch. SL 2011-117	03-10-11	04-14-11
S0307=	Fletcher L. Hart	SMART CARD BIOMETRICS AGAINST MEDICAID FRAUD.	*SR Ch. SL 2011-117	04-19-11	04-21-11
S0316=	Fletcher L. Hart	ADD'L SECTION 1915 MEDICAID WAIVER SITES.	*SR Ch. SL 2011-102	03-14-11	03-17-11
S0346	Eleanor Kinnaird	EXEMPT COOKING SCHOOLS FROM FOOD REGULATIONS.	*S Pres. To Gov. 6/20/2011	03-16-11	03-30-11
S0347	William R. Purce	REPORT HEALTH CARE-ASSOCIATED INFECTIONS.	S Ref To Com On Health and Human Services	03-16-11	03-30-11
S0354	Stan Bingham	RENTAL PROPERTY/ LITHIUM BATTERY SMOKE ALARMS.	*S Ref to the Com on Commerce and Job Development, if favorable, Judiciary	04-19-11	05-04-11
S0375	Josh Stein	FACILITATE STATEWIDE HEALTH INFO. EXCHANGE.	*S Pres. To Gov. 6/20/2011	03-21-11	03-31-11
S0384=	Fletcher L. Hart	CONFORMING CHANGES/ PERSONS W/ DISABILITIES ACT.	SR Ch. SL 2011-94	03-22-11	03-30-11
S0402=	Stan Bingham	EXTEND HEARING LOSS TASK FORCE.	S Ref To Com On Health Care	03-24-11	
S0422	Stan Bingham	DHHS STUDY OF IOM TASK FORCE RECOM 3.1.	S Ref To Com On Health Care	03-28-11	
S0433=	Fletcher L. Hart	LOCAL HUMAN SERVICES ADMINISTRATION.	*S Re-ref Com On Health and Human Services	03-29-11	04-06-11
S0437=	Fletcher L. Hart	ENACT FIRST EVALUATION PROGRAM.	*S Pres. To Gov. 6/20/2011	03-29-11	04-14-11
S0449=	Stan Bingham	TASK FORCE ON FRAUD AGAINST OLDER ADULTS.	*S Pres. To Gov. 6/17/2011	03-30-11	04-20-11
S0450=	Stan Bingham	DIRECT CARE WORKER WAGE AND BENEFIT STUDY.	*S Ref To Com On Health and Human Services	03-30-11	04-21-11
S0451=	Stan Bingham	EXTEND REPORTING ON BABY BOOMER PREPARATIONS.	S Ref To Com On Health and Human Services	03-30-11	04-20-11

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2011-2012 Biennium

Leg. Day: H-087/S-087

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
S0467=	Fletcher L. Hart	NATUROPATHIC LICENSING ACT.	*S	Re-ref Com On Finance	03-31-11	06-14-11
1471	William R. Purce	YOUTH SKIN CANCER PREVENTION ACT.	*S	Re-ref Com On Commerce	03-31-11	05-12-11
S0496	Louis Pate	MEDICAID AND HEALTH CHOICE PROVIDER REQ.	*S	Pres. To Gov. 6/20/2011	04-04-11	06-06-11
S0505=	Fletcher L. Hart	EQUAL TREATMENT UNDER SMFP.	S	Ref To Com On Health Care	04-05-11	
S0508	Eleanor Kinnaird	CLARIFY VACCINE EXEMPTIONS/EMERG. MGMT ACT.	S	Ref To Com On Health and Human Services	04-05-11	06-08-11
S0512	Debbie A. Clary	AUTHORIZE OVERNIGHT RESPITE PILOT.	*SR	Ch. SL 2011-104	04-06-11	05-12-11
S0528	William R. Purce	ACCESSIBLE ELECTRONIC INFO ACT/BLIND/DISABLED.	S	Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	04-07-11	
S0551	Fletcher L. Hart	ESTABLISH STATE PUBLIC HEALTH AUTHORITY.	S	Ref To Com On Health Care	04-12-11	
S0552	Fletcher L. Hart	INCENTIVE PROGRAM FOR PUBLIC HEALTH IMPROV.	*S	Ref To Com On Health and Human Services	04-12-11	06-06-11
\$ S0567=	Peter S. Brunste	STATEWIDE ENTERPRISE FRAUD/WASTE DETECTION.	S	Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	04-14-11	
S0573	Gladys A. Robins	RESTRICT PRODUCTS CONTAINING BPA.	S	Ref To Com On Health Care	04-14-11	
0597=	William R. Purce	BEHAVIORAL HEALTH SERVICES FOR MILITARY.	*SR	Ch. SL 2011-185	06-08-11	06-08-11
S0607	Josh Stein	CONFORM MEDICAL RECORD LAWS.	*S	Pres. To Gov. 6/20/2011	04-19-11	04-28-11
S0608=	Neal Hunt	HEALTH CARE SHARING ORGANIZATIONS.	SR	Ch. SL 2011-103	04-19-11	04-27-11
S0609	David Rouzer	FACILITATE LOCUM TENENS PHYSICIANS.	*S	Pres. To Gov. 6/20/2011	04-19-11	04-27-11
S0617	Bob Atwater	LRC STUDY FOOD ALLERGY & ANAPHYLAXIS MGMT.	*S	Re To Com On Health and Human Services	04-19-11	06-06-11
S0644	David Rouzer	DSS ADOPTION ASSISTANCE AGREEMENTS BINDING.	*S	Pres. To Gov. 6/20/2011	04-19-11	05-12-11
S0655=	Louis Pate	DENTISTRY MANAGEMENT ARRANGEMENTS.	S	Re-ref Com On Health and Human Services	04-20-11	06-07-11
S0662=	Stan Bingham	MIDWIFERY LICENSING ACT.	S	Ref To Com On Health Care	04-20-11	
S0670	Fletcher L. Hart	REVISE MEMBERSHIP/ HEARING AID FITTERS BOARD.	*S	Pres. To Gov. 6/20/2011	04-20-11	05-12-11
S0696	Josh Stein	ADDRESS PRIMARY CARE SHORTAGE.	*S	Ref To Com On Rules, Calendar, and Operations of	06-06-11	06-08-11

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2011-2012 Biennium

Bill	Introducer	Short Title	Latest Action	In Date	Out Date
~2697	Josh Stein	PATIENT ADVOCACY & PROTECTION ACT.	*S Ref To Com On Health and Human Services	06-07-11	06-08-11
S0717	Eric Mansfield	PHOTO I.D. FOR SNAP RECIPIENTS.	S Re-ref Com On Health Care	06-06-11	
S0718	Eric Mansfield	PRESCRIPTION INTEGRITY ACT.	S Ref To Com On Health Care	04-20-11	
S0743	Thom Goolsby	ENCOURAGE VOLUNTEER HEALTH CARE PROVIDERS.	*S Pres. To Gov. 6/20/2011	04-20-11	05-24-11
S0744	Thom Goolsby	TRANSPARENCY IN THE COST OF HEALTH CARE.	*S Ref To Com On Insurance	04-20-11	04-27-11
S0766	Andrew C. Brock	NOTARIZED CONSENT FOR MINOR'S ABORTION.	S Ref To Com On Health Care	04-20-11	
S0769=	Andrew C. Brock	ABORTION-WOMAN'S RIGHT TO KNOW ACT.	S Ref To Com On Health Care	04-20-11	
S0770	Andrew C. Brock	BIRTH CERTIFICATE/ STILLBORN INFANTS.	*S Pres. To Gov. 6/20/2011	04-20-11	06-08-11
S0775	Andrew C. Brock	REGULATE ABORTION FACILITIES.	S Ref To Com On Health Care	04-20-11	

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SENATE HEALTH CARE COMMITTEE

March 16, 2011

MINUTES

The Senate Health Care Committee met on Wednesday, March 16, 2011 in Room 544 of the Legislative Office Building. Fifteen members were in attendance along with staff Shawn Parker, Theresa Matula, Amy Jo Johnson, and Susan Barham.

Senator Bingham called the meeting to order at 11:04am and introduced the Sergeant-at-Arms and the Pages. The first bill to be considered was Senate Bill 248, AN ACT TO UPDATE CERTAIN TERMINOLOGY IN REFERENCE TO PERSONS WITH DISABILITIES, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION. (attached) This bill was sponsored and explained by Senator Hartsell. After discussion, a motion was made by Co-chairman Pate for a favorable report. The motion carried and the bill was given a favorable report.

Senator Purcell made a motion to consider Proposed Committee Substitute 245, AN ACT TO AUTHORIZE LOCAL PUBLIC HEALTH DEPARTMENTS, AND CONSOLIDATED HUMAN SERVICES AGENCIES TO BILL MEDICAID THROUGH AN APPROVED MEDICAID CLEARINGHOUSE OR THROUGH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH (attached). The motion carried and the bill's sponsor, Senator Hartsell explained the bill. After discussion and questions, Senator Kinnaird made a motion which carried. The bill was reported as unfavorable as to bill, but favorable as to committee substitute bill.

Senator Bingham recognized former Senator Bob Carpenter in the audience. He then asked the members of the Committee to introduce themselves because this was the inaugural Health Care meeting for this session.

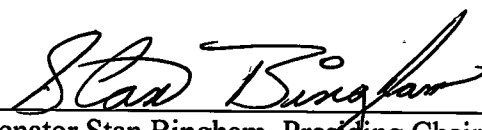
Senator Bingham introduced Representative Pierce, who proceeded to explain the last bill to be considered, House Bill 60, AN ACT TO EXTEND THE TASK FORCE DEVELOPING GUIDELINES FOR CONSUMERS TO USE WHEN PURCHASING A HEARING AID, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING. (attached) After discussion, Senator Purcell made a motion which carried. The bill was given a favorable report.

Senator Rabon was recognized by the Chair so that he could introduce Tommy Harrelson in the audience.

The meeting was adjourned at 11:49am.

Respectfully submitted,


Maria Kinnaird, Committee Assistant


Senator Stan Bingham, Presiding Chair

Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-chair

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 16, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 60	Extend Hearing Loss Task Force.	Representative Mobley Representative Pierce Representative Farmer- Butterfield Representative Weiss
SB 245	Medicaid Billing by Local Health Departments.	Senator Hartsell
SB 248	Update Archaic Disability Terms.	Senator Hartsell

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee
Wednesday, March 16, 2011, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 245	Medicaid Billing by Local Health Departments.	Senator Hartsell
SB 248	Update Archaic Disability Terms.	Senator Hartsell
HB 60	Extend Hearing Loss Task Force.	Representative Mobley
		Representative Pierce
		Representative Farmer-
		Butterfield
		Representative Weiss

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, March 16, 2011

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

FAVORABLE

S.B.	248	Update Archaic Disability Terms.	
		Sequential Referral:	None
		Recommended Referral:	None
H.B.	60	Extend Hearing Loss Task Force.	
		Sequential Referral:	None
		Recommended Referral:	None

TOTAL REPORTED: 2

Committee Clerk Comments:

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Thursday, March 17, 2011

Senator BINGHAM,

submits the following with recommendations as to passage:

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

S.B. 245 Medicaid Billing by Local Health Departments.

Draft Number: 85097

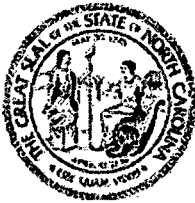
Sequential Referral: None

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 1

Committee Clerk Comments:



SENATE BILL 248: Update Archaic Disability Terms

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: First Edition

Date: March 11, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *Senate Bill 248 revises the North Carolina General Statutes by implementing the recommendations of the General Statutes Commission to replace terms that may be regarded as derogatory and to utilize gender-neutral language.*

[As introduced, this bill was identical to H249, as introduced by Rep. Ross, which is currently in House Judiciary Subcommittee A.]

BILL ANALYSIS: Senate Bill 248 amends the following statutes as follows:

Section 1- replaces the terms "infant", "lunatic", and "insolvent" with the terms "minor", "incompetent person", and "insolvent person" in a provision.

The term incompetent adult/child is defined in Chapter 35A of the General Statutes as an individual who lacks sufficient capacity to manage their own affairs or to make or communicate important decisions concerning the individual's person, family, or property whether the lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury, or similar cause or condition.

Section 2- utilizes gender neutral language and replaces the term "committee" with "guardian" and replaces the term "lunatic" with the term "incompetent person".

Section 3- replaces the term "defect" with "disability/disabled", the term "dumb" with "mute" and deletes a superfluous reference to the condition of prohibited false representation.

Section 4- utilizes gender neutral language and replaces the term "infant" and "lunatic" with the terms "minor" and "is incompetent" respectively.

Section 5- directs the State Banking Commission to its definition of the term "fiduciary" to avoid the use of the word "lunatic" the next time it amends 04 NCAC 03D.0301.

CURRENT LAW:

The General Statutes Commission is established by Article 2 of Chapter 164 of the North Carolina General Statutes to along with its other duties make a continual study of all matters involved in the preparation and publication of modern codes of law.

Session Law 2009-264 directs the General Statutes Commission to review and recommend any statutory changes and drafting policies needed to make the General Statutes and administrative rules refer to a person with a disability as a person first.

Session Law 2009-273 directs the General Statutes Commission to study and recommend ways to make the General Statutes and the North Carolina Constitution gender neutral.

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

S248-SMSQ-3(e1) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 248*

Short Title: Update Archaic Disability Terms. (Public)

Sponsors: Senators Hartsell; and Atwater.

Referred to: Health Care.

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO UPDATE CERTAIN TERMINOLOGY IN REFERENCE TO PERSONS WITH
DISABILITIES, AS RECOMMENDED BY THE GENERAL STATUTES
COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 1-255 reads as rewritten:

"§ 1-255. Who may apply for a declaration.

Any person interested as or through an executor, administrator, trustee, guardian or other
fiduciary, creditor, devisee, legatee, heir, next of kin, or cestui que trust, in the administration
of a trust, or of the estate of a decedent, an infant, lunatic, or insolvent, a minor, an incompetent
person, or an insolvent person, may have a declaration of rights or legal relations in respect
thereto:

- (1) To ascertain any class of creditors, devisees, legatees, heirs, next of kin or
others; or
- (2) To direct the executors, administrators, or trustees to do or abstain from
doing any particular act in their fiduciary capacity; or
- (3) To determine any question arising in the administration of the estate or trust,
including questions of construction of wills and other writings.
- (4) To determine the apportionment of the federal estate tax, interest and
penalties under the provisions of Article 27 of Chapter 28A."

**SECTION 2. Rule 601 of the North Carolina Rules of Evidence, as contained in
G.S. 8C-1, reads as rewritten:**

"Rule 601. General rule of competency; disqualification of witness.

(a) General rule. – Every person is competent to be a witness except as otherwise
provided in these rules.

(b) Disqualification of witness in general. – A person is disqualified to testify as a
witness when the court determines that ~~he~~the person is (1) incapable of expressing himself or
herself concerning the matter as to be understood, either directly or through interpretation by
one who can understand ~~him~~him or her, or (2) incapable of understanding the duty of a witness
to tell the truth.

(c) Disqualification of interested persons. – Upon the trial of an action, or the hearing
upon the merits of a special proceeding, a party or a person interested in the event, or a person
from, through or under whom such a party or interested person derives his or her interest or title
by assignment or otherwise, shall not be examined as a witness in his or her own behalf or
interest, or in behalf of the party succeeding to his or her title or interest, against the executor,
administrator or survivor of a deceased person, or the ~~committee of a lunatic, guardian of an
incompetent person,~~ or a person deriving his or her title or interest from, through or under a



1 ~~deceased or incompetent person or lunatic~~, by assignment or otherwise, concerning any oral
2 communication between the witness and the deceased ~~person or lunatic or incompetent person~~.
3 However, this subdivision shall not apply when:

- 4 (1) The executor, administrator, survivor, ~~committee-guardian~~, or person so
5 deriving title or interest is examined in his or her own behalf regarding the
6 subject matter of the oral communication.
7 (2) The testimony of the ~~lunatic or deceased~~ or incompetent person is given in
8 evidence concerning the same transaction or communication.
9 (3) Evidence of the subject matter of the oral communication is offered by the
10 executor, administrator, survivor, ~~committee-guardian~~ or person so deriving
11 title or interest.

12 Nothing in this subdivision shall preclude testimony as to the identity of the operator of a motor
13 vehicle in any case."

14 **SECTION 3. G.S. 14-113 reads as rewritten:**

15 **"§ 14-113. Obtaining money by false representation of physical defect-disability.**

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

22 **SECTION 4. G.S. 43-12 reads as rewritten:**

23 **"§ 43-12. Effect of decree; approval of judge.**

24 Every decree rendered as hereinbefore provided shall bind the land and bar all persons and
25 corporations claiming title thereto or interest therein; quiet the title thereto, and shall be forever
26 binding and conclusive upon and against all persons and corporations, whether mentioned by
27 name in the order of publication, or included under the general description, "to whom it may
28 concern"; and every such decree so rendered, or a duly certified copy thereof, as also the
29 certificate of title issued thereon to the person or corporation therein named as owner, or to any
30 subsequent transferee or purchaser, shall be conclusive evidence that such person or
31 corporation is the owner of the land therein described, and no other evidence shall be required
32 in any court of this State of ~~his~~ his, her, or its right or title thereto. It shall not be an exception
33 to such conclusiveness that ~~the a person is an infant, lunatic a minor, is incompetent~~, or is under
34 any disability, but such person may have recourse upon the indemnity fund hereinafter
35 provided for, for any loss ~~he~~ the person may suffer by reason of being so concluded.
36 Notwithstanding the provisions of G.S. 43-10, such decrees shall not be binding on and include
37 the State of North Carolina or any of its agencies unless the State of North Carolina is made a
38 party to the proceeding and notice of said proceeding and copy of petition, etc., are served upon
39 the State of North Carolina as provided in this Chapter. Such decrees shall, in addition to being
40 signed by the clerk of the court, be approved by the judge of the superior court, who shall
41 review the whole proceeding and have power to require any reformation of the process,
42 pleading, decrees or entries."

43 **SECTION 5. On the next occasion that the State Banking Commission amends 04**
44 **NCAC 03D .0301, the Commission shall revise the definition of "fiduciary" so that it no longer**
45 **contains the word "lunatics."**

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



SENATE BILL 248: Update Archaic Disability Terms

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: First Edition

Date: March 11, 2011
Prepared by: Shawn Parker
Committee Counsel

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[As introduced, this bill was identical to H249, as introduced by Rep. Ross, which is currently in House Judiciary Subcommittee A.]

BILL ANALYSIS: Senate Bill 248 amends the following statutes as follows:

Section 1- replaces the terms "infant", "lunatic", and "insolvent" with the terms "minor", "incompetent person", and "insolvent person" in a provision.

The term incompetent adult/child is defined in Chapter 35A of the General Statutes as an individual who lacks sufficient capacity to manage their own affairs or to make or communicate important decisions concerning the individual's person, family, or property whether the lack of capacity is due to mental illness, mental retardation, epilepsy, cerebral palsy, autism, inebriety, senility, disease, injury, or similar cause or condition.

Section 2- utilizes gender neutral language and replaces the term "committee" with "guardian" and replaces the term "lunatic" with the term "incompetent person".

Section 3- replaces the term "defect" with "disability/disabled", the term "dumb" with "mute" and deletes a superfluous reference to the condition of prohibited false representation.

Section 4- utilizes gender neutral language and replaces the term "infant" and "lunatic" with the terms "minor" and "is incompetent" respectively.

Section 5- directs the State Banking Commission to its definition of the term "fiduciary" to avoid the use of the word "lunatic" the next time it amends 04 NCAC 03D.0301.

CURRENT LAW:

The General Statutes Commission is established by Article 2 of Chapter 164 of the North Carolina General Statutes to along with its other duties make a continual study of all matters involved in the preparation and publication of modern codes of law.

Session Law 2009-264 directs the General Statutes Commission to review and recommend any statutory changes and drafting policies needed to make the General Statutes and administrative rules refer to a person with a disability as a person first.

Session Law 2009-273 directs the General Statutes Commission to study and recommend ways to make the General Statutes and the North Carolina Constitution gender neutral.

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

S248-SMSQ-3(e1) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 245
PROPOSED COMMITTEE SUBSTITUTE S245-CSTK-2 [v.1]

3/14/2011 4:13:56 PM

Short Title: Medicaid Billing by Local Health Departments.

(Public)

Sponsors:

Referred to:

March 8, 2011

- 1 A BILL TO BE ENTITLED
2 AN ACT TO AUTHORIZE LOCAL PUBLIC HEALTH DEPARTMENTS, DISTRICT
3 HEALTH DEPARTMENTS, AND CONSOLIDATED HUMAN SERVICES AGENCIES
4 TO BILL MEDICAID THROUGH AN APPROVED MEDICAID CLEARINGHOUSE
5 OR THROUGH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
6 DIVISION OF PUBLIC HEALTH.
7 The General Assembly of North Carolina enacts:
8 SECTION 1. Part 1A of Article 2 of Chapter 130A of the General Statutes is
9 amended by adding a new section to read:
10 "§ 130A-34.2. Billing of Medicaid.
11 (a) Local health departments, district health departments, and consolidated human
12 services agencies shall have the following two options to bill public health program services to
13 Medicaid:
14 (1) Submit claim data to HIS and manage 837/835 billing files within HIS.
15 (2) Submit claim data to any approved Medicaid clearinghouse and manage
16 837/835 billing files within that system.
17 (b) The Division of Public Health may require local health departments, district health
18 departments, and consolidated human services agencies, regardless of how those entities
19 choose to bill public health program services to Medicaid, to submit aggregate data to the
20 Division of Public Health.
21 (c) Local health departments, district health departments, and consolidated human
22 services agencies shall not be required under this section to submit encounter level data to the
23 Division of Public Health or the Health Information System.
24 (d) Local health departments, district health departments, and consolidated human
25 services agencies that bill services through a Medicaid clearinghouse shall be entitled to the
26 same reimbursement rates negotiated for agencies classified as public health entities and the
27 same Medicaid cost settlement reimbursement as those agencies that bill services through HIS.
28 (e) The Division of Public Health shall provide aggregate data requirements for the
29 purposes of Medicaid cost study reimbursement on behalf of the local health departments,
30 district health departments, and consolidated human services agencies that choose to bill
31 services through a Medicaid clearinghouse. Those local health departments, district health
32 departments, and consolidated human services agencies shall submit to the Division of Public
33 Health the data required for the purposes of Medicaid cost study reimbursement.
34 (f) As used in this Section, unless otherwise specified:



* S 2 4 5 - C S T K - 2 - V - 1 *

- 1 (1) "Aggregate data" means high-level reports about services provided, such as
2 the number of patients meeting particular criteria served by a health
3 department or the count of a particular service being performed by a health
4 department.
5 (2) "Encounter level data" means patient identified data specific to each medical
6 encounter used to bill medical services.
7 (3) "Health Information System" or "HIS" means the system operated by the
8 North Carolina Division of Public Health and used by local health
9 departments to record information about services the local health
10 departments provide.
11 (4) "Public health program services" means services normally provided by a
12 local health department under agreements with the North Carolina Division
13 of Public Health or the North Carolina Division of Medical Assistance."

14 **SECTION 3.** This act is effective when it becomes law and applies to Medicaid
15 claims arising on and after that date.



SENATE PCS 245: Medicaid Billing by Local Health Departments

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S245-CSTK-2

Date: March 14, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The Proposed Committee Substitute for Senate Bill 245 would authorize local public health departments, district health departments, and consolidated human service agencies to bill Medicaid through a clearinghouse or through the Health Information System (HIS). This bill would be effective when it becomes law and would apply to Medicaid claims arising on and after that date.*

CURRENT LAW: Currently only public health authority boards are allowed to contract with private vendors to operate their Medicaid billing systems under G.S. § 130A-45.13. At this time, local public health departments, district health departments, and consolidated human service agencies are using the Health Information System (HIS).

BILL ANALYSIS: This bill would allow local public health departments, district health departments and consolidated human service agencies to bill Medicaid using a clearinghouse. Local public health departments, district health departments and consolidated human services agencies would have the choice of using a Medicaid clearinghouse or the HIS. Additionally, the bill states that reimbursement rates will remain the same regardless of whether the billing entity uses HIS or a clearinghouse. Finally, the bill allows for high-level reports about services provided to be collected by the Division of Public Health regardless of billing method.

EFFECTIVE DATE: The bill is effective when it becomes law and will apply to Medicaid claims arising on or after that date.

S245-SMTK-5(CSTK-2) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 245

Short Title: Medicaid Billing by Local Health Departments. (Public)

Sponsors: Senators Hartsell; Atwater and Mansfield.

Referred to: Health Care.

March 8, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO AUTHORIZE LOCAL PUBLIC HEALTH DEPARTMENTS TO BILL
3 MEDICAID THROUGH AN APPROVED MEDICAID CLEARINGHOUSE OR
4 THROUGH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION
5 OF PUBLIC HEALTH.

6 The General Assembly of North Carolina enacts:

7 SECTION 1. G.S. 130A-45.01 reads as rewritten:

8 "§ 130A-45.01. Definitions.

9 As used in this Part, unless otherwise specified:

- 10 (1) "Aggregate data" means high-level reports about services provided, such as
11 the number of patients meeting particular criteria served by a health
12 department or the count of a particular service being performed by a health
13 department.
- 14 (1)(2) "Authority service area" means the area within the boundaries of the
15 authority as provided for in G.S. 130A-45.4.
- 16 (2)(3) "Board" means a public health authority board created under this Part.
- 17 (3)(4) "County" means the county which is, or is about to be, included in the
18 territorial boundaries of a public health authority when created hereunder.
- 19 (4)(5) "County board of commissioners" means the legislative body charged with
20 governing the county.
- 21 (5)(6) "Department" means the Department of Health and Human Services.
- 22 (7) "Encounter level data" means patient identified data specific to each medical
23 encounter used to bill medical services.
- 24 (6)(8) "Federal government" means the United States of America, or any agency,
25 instrumentality, corporate or otherwise, of the United States of America.
- 26 (7)(9) "Government" means the State and federal governments and any
27 subdivision, agency, or instrumentality, corporate or otherwise, of either of
28 them.
- 29 (10) "Health Information System" or "HIS" means the system operated by the
30 North Carolina Division of Public Health and used by local health
31 departments to record information about services the local health
32 departments provide.
- 33 (8)(11) "Public health authority" means a public body and a body corporate and
34 politic organized under the provisions of this Part.
- 35 (9)(12) "Public health facility" means any one or more buildings, structures,
36 additions, extensions, improvements, or other facilities, whether or not
37 located on the same site or sites, machinery, equipment, furnishings or other



real or personal property suitable for providing public health services; and includes, without limitation, local public health departments or centers; public health clinics and outpatient facilities; nursing homes, including skilled nursing facilities and intermediate care facilities, adult care homes for the aged and disabled; public health laboratories; administration buildings, central service and other administrative facilities; communication, computer and other electronic facilities; pharmaceutical facilities; storage space; vehicular parking lots and other such public health facilities, customarily under the jurisdiction of or provided by public health departments, or any combination of the foregoing, with all necessary, convenient or related interests in land, machinery, apparatus, appliances, equipment, furnishings, appurtenances, site preparation, landscaping, and physical amenities.

(13) "Public health program services" means services normally provided by a local health department under agreements with the North Carolina Division of Public Health or the North Carolina Division of Medical Assistance.

~~(14)~~(14) "Real property" means lands, lands under water, structures, and any and all easements, franchises and incorporeal hereditaments and every estate and right therein, legal and equitable, including terms for years and liens by way of judgment, mortgage or otherwise.

~~(15)~~(15) "State" means the State of North Carolina."

SECTION 2. Part 1B of Article 2 of Chapter 130A of the General Statutes is amended by adding a new section to read:

"§ 130A-45.14. Local health department billing of Medicaid.

(a) Local health departments shall have the following two options to bill public health program services to Medicaid:

(1) Submit claim data to HIS and manage 837/835 billing files within HIS.

(2) Submit claim data to any approved Medicaid clearinghouse and manage 837/835 billing files within that system.

(b) The Division of Public Health may require local health departments, regardless of how those local health departments choose to bill public health program services to Medicaid, to submit aggregate data to the Division of Public Health.

(c) Local health departments shall not be required under this section to submit encounter level data to the Division of Public Health or the Health Information System.

(d) Local health departments that bill services through a Medicaid clearinghouse shall be entitled to the same reimbursement rates negotiated for agencies classified as public health entities and the same Medicaid cost settlement reimbursement as those agencies that bill services through HIS.

(e) The Division of Public Health shall provide aggregate data requirements for the purposes of Medicaid cost study reimbursement on behalf of the local health departments that choose to bill services through a Medicaid clearinghouse. Those local health departments shall submit to the Division of Public Health the data required for the purposes of Medicaid cost study reimbursement."

SECTION 3. This act becomes effective October 1, 2011.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

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HOUSE BILL 60

Short Title: Extend Hearing Loss Task Force. (Public)

Sponsors: Representatives Pierce, Farmer-Butterfield, Weiss, and Mobley (Primary Sponsors).

For a complete list of Sponsors, see Bill Information on the NCGA Web Site.

Referred to: Health and Human Services.

February 9, 2011

A BILL TO BE ENTITLED
AN ACT TO EXTEND THE TASK FORCE DEVELOPING 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:

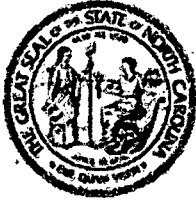
SECTION 1. Section 1 of S.L. 2010-121 reads as rewritten:

"**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 aids, as recommended by the NC Hearing Aid Dealers and Fitters Board; a consumer of hearing aids, 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, ~~2010-2010~~, and on or before November 15, 2011."

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





HOUSE BILL 60: Extend Hearing Loss Task Force

2011-2012 General Assembly

Committee:	Senate Health Care	Date:	March 15, 2011
Introduced by:	Reps. Pierce, Farmer-Butterfield, Weiss, Mobley	Prepared by:	Susan Barham Research Assistant
Analysis of:	First Edition		

SUMMARY: *The House Bill 60 adds an additional reporting date requiring the Hearing Loss Task Force to present its findings and recommendations to the North Carolina Study Commission on Aging and the Joint Legislative Health Care Oversight Committee on or before November 15, 2011, as recommended by the North Carolina Study Commission on Aging.*

BILL ANALYSIS:

House Bill 60 amends Section 1(b) of S.L. 2010-121 and directs the Hearing Loss Task Force to submit an additional report on the findings and recommendations of the Task Force, on or before November 15, 2011.

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

BACKGROUND:

Session Law 2010-121 directed the Hearing Aid Dealers and Fitters Board to coordinate a task force to develop guidelines for individuals seeking information on the purchase of hearing aids and to report findings and recommendations to the North Carolina Study Commission on Aging and the Joint Legislative Health Care Oversight Committee. The task force presented its report to the North Carolina Study Commission on Aging, on January 25, 2011. The report included a recommendation that the task force continue to meet for one more year to further address the needs of people with hearing loss in North Carolina.

In support of the task force's request to continue their work, the North Carolina Study Commission on Aging recommended, in their report to the Governor and the 2011 Regular Session of the General Assembly, that the General Assembly amend Session Law 2010-121 to extend the task force and provide another reporting opportunity through the enactment of House Bill 60.

H60-SMTE-2(e1) v1

VISITOR REGISTRATION SHEET

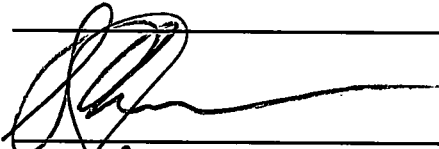
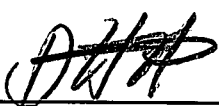
Committee on Health Care

Name of Committee

Wednesday, March 16, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	
	DMA
My ~~Bill~~	AMAR - NC
Jame King	NCMS
Kay Emanuel	Legislative Reporting Services
Dana M. Hoff	Policy Group
Jeri Alling	BEGINNINGS
Barbara Caslow	Page
Nicole Fisher	John Locke Foundation
Tom McDevitt	Evergreen Foundation
Bob Carpenter	Evergreen Foundation

VISITOR REGISTRATION SHEET

Committee on Health Care

Name of Committee

Wednesday, March 16, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

John Banknight	EVERGLADE FD
Paul R. ...	TL / TR
T. ...	CFTF
... ..	DPH - NC
Mary Perkins ...	SEANC
Sharon Sharpe	SEANC
Don Cavellini	101 Lancaster Dr Pitt Co - Greenville
Steve Mitchell	Astoria
Henry Hutaff	N.C.B.A.
Robin Cunningham	South Hills Hallmark
M. H. Wolfe	Parker Poe

VISITOR REGISTRATION SHEET

Committee on Health Care

Name of Committee

Wednesday, 16 March, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Mahan	ASNC
Annaliese Polph	BRNC
Daniel Baum	TROUTMAN SANDERS
STEVE MITCHELL	ASTELLAS
Andrew Bailey	UNCW
Fornyst William	Govt Office
Kay Paksoy	NASW NC
Michelle Morley	NABW NC
Emily Grimm	mwc
Phil White	HLA

VISITOR REGISTRATION SHEET

H. Keith Cole
~~Senate Committee on Education/Higher Education~~

Wednesday, March 16, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Floyd Lewis	General Statutes Commission
P. Ben Hall	depto
JOANNE MCISAAC	STUDENT LOYOLA UNIV
KEITH MCISAAC	CITIZEN
John McMillan	MFOS
Michelle Francis	MFOS
Matt Martin	Central Carolina Surgery - Greensboro
Wilma Burton	Hick Pt. Med. Society
Mark Warburton	High Point On the Committee Health Care
Perry E. Jones, MD	Caroline, West Hes. block High Point, NC
Caroline Denning	NMSS-NC

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, March 30, 2011

Room 544, LOB

The Senate Committee on Health Care met at 11:00 a.m. on Wednesday, March 30, 2011, in Room 544 of the Legislative Office Building. Sixteen members were present, with Senator Louis Pate presiding.

Senator Pate called the meeting to order, welcomed everyone and introduced the Sergeants-at-Arms: David Goldberg, Jon Fitchett and Stan Johnson. He then introduced the Pages assisting with the meeting: Lauren Poythress from Morrisville, sponsored by Senator Berger and Jordan Laughinghouse also from Morrisville, sponsored by Senator Forrester.

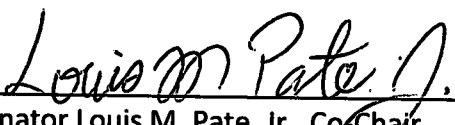
Senator Pate recognized Senator Kinnaird to explain SB 346, "Exempt Cooking Schools from Food Regulations." After completing her explanation and answering questions, Senator Pate asked for motions. Senator Bingham made a motion for a Favorable Report. The motion passed.

SB 347, "Report Health Care Associated Infections" was brought before the Committee next for consideration. Senator Purcell explained the bill and answered all questions satisfactorily. Senator Bingham made a motion for a Favorable Report and the motion passed.

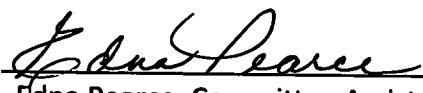
SB 384, "Conforming Changes/Persons W/Disabilities Act" was the next bill brought before the Committee for consideration. Senator Hartsell was recognized to explain the bill. Senator Tucker made a motion for a Favorable Report; the motion carried.

Senator Pate then called on Senator Stein to explain SB 375, "Facilitate Statewide Health Information Exchange." After answering several questions from members, the motion was made by Senator Mansfield for an Unfavorable Report on the original bill, with a Favorable Report on the PCS. Motion carried.

Senator Pate adjourned the meeting at 11:45 a.m.



Senator Louis M. Pate, Jr., Co-Chair



Edna Pearce, Committee Assistant

Edna Pearce (Sen. Pate)

From: Maria Kinnaird (Sen. Bingham)
At: Thursday, March 24, 2011 11:29 AM
Subject: Anna Kidd (Sen. Blake); Edna Pearce (Sen. Pate)
<NCGA> Senate Health Care Committee Meeting Notice for Wed, 03-30-2011 at 11:00 AM

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 30, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 346	Exempt Cooking Schools from Food Regulations.	Senator Kinnaird
SB 347	Report Health Care-Associated Infections.	Senator Mansfield Senator Bingham Senator Purcell
SB 384	Conforming Changes/Persons W/Disabilities Act.	Senator Hartsell
SB 375	Facilitate Statewide Health Info. Exchange.	Senator Stein Senator Brunstetter

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

AGENDA

SENATE HEALTH CARE COMMITTEE

MARCH 30, 2011

SENATOR LOUIS M. PATE, JR. PRESIDING

CALL TO ORDER

WELCOME MEMBERS AND GUEST

RECOGNIZE: SGTS. AT ARMS:

David Goldberg
Jon Fitchett
Stan Johnson

PAGES:

DISCUSS BILLS

SENATE HEALTH CARE COMMITTEE

Wednesday, March 30, 2011

Room 544 LOB

11:00 AM

Senator Louis Pate, Presiding

AGENDA

WELCOME AND OPENING REMARKS

BILLS TO BE CONSIDERED

SB 346 Exempt Cooking Schools from Food Regulations

SB 347 Report Health Care Associated Infections

SB 384 Conforming Changes/Persons W/Disabilities Act

SB 375 Facilitate Statewide Health Info. Exchange

BILL SPONSORS

**Senator Kinnaird
Senator Graham
Senator McKissick**

**Senator Purcell
Senator Bingham
Senator Mansfield**

Senator Hartsell

**Senator Stein
Senator Brunstetter**

OTHER BUSINESS

ADJOURNMENT

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, March 30, 2011

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

FAVORABLE

S.B.	346	Exempt Cooking Schools from Food Regulations.
		Sequential Referral: None
		Recommended Referral: None
S.B.	347	Report Health Care-Associated Infections.
		Sequential Referral: None
		Recommended Referral: None
S.B.	384	Conforming Changes/Persons W/Disabilities Act.
		Sequential Referral: None
		Recommended Referral: None

TOTAL REPORTED: 3

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 347

Short Title: Report Health Care-Associated Infections. (Public)

Sponsors: Senators Purcell, Bingham, and Mansfield.

Referred to: Health Care.

March 16, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
ESTABLISH A STATEWIDE SURVEILLANCE AND REPORTING SYSTEM FOR
HEALTH CARE-ASSOCIATED INFECTIONS AND TO SUBJECT HOSPITALS TO
THE REQUIREMENTS OF THE STATEWIDE SURVEILLANCE AND REPORTING
SYSTEM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 6 of Chapter 130A of the General Statutes is amended by
adding a new Part to read:

"Part 1A. Health Care-Associated Infections.

"§ 130A-150. Statewide surveillance and reporting system.

(a) By December 31, 2011, the Department shall establish a statewide surveillance and
reporting system for specified health care-associated infections in accordance with rules
adopted by the Commission pursuant to subsection (b) of this section.

(b) The Commission shall adopt rules necessary to implement the statewide
surveillance and reporting system established pursuant to subsection (a) of this section. The
rules shall specify uniform standards for surveillance and reporting of specified health
care-associated infections under the statewide surveillance and reporting system. The uniform
standards shall include at least all of the following:

(1) A preference for electronic surveillance of specified health care-associated
infections to the greatest extent practicable.

(2) A requirement for electronic reporting of specified health care-associated
infections.

(c) Each hospital, as defined in G.S. 131E-76(3), is subject to the statewide surveillance
and reporting system established in accordance with subsection (a) of this section and shall be
responsible for health care-associated infections surveillance and reporting of specified health
care-associated infections data to the Department through the Centers for Disease Control and
Prevention National Health Care Safety Network.

(d) The Department may release to the public aggregated data on health care-associated
infections that does not contain social security numbers or other personal identifying
information only if it deems the release of this data to be in the public interest."

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



* S 3 4 7 - V - 1 *



SENATE BILL 347: Report Health Care-Associated Infections

2011-2012 General Assembly

Committee:	Senate Health Care	Date:	March 29, 2011
Introduced by:	Sens. Purcell, Bingham, Mansfield	Prepared by:	Susan Barham
Analysis of:	First Edition		Research Assistant

SUMMARY: *Senate Bill 347 establishes a statewide surveillance and reporting system for certain health care associated infections.*

BILL ANALYSIS:

Senate Bill 347 amends Article 6 of Chapter 130A by adding a new Part 1A that directs the Department of Health and Human Services (Department) to establish a statewide surveillance and reporting system for health care-associated infections (HAI). The bill directs the Commission for Public Health to adopt rules to implement a statewide HAI reporting system. The rules must specify uniform standards including, at a minimum, a preference for electronic surveillance and a requirement of electronic reporting.

All 124 hospitals licensed by the Division of Health Service Regulation are subject to the statewide surveillance and reporting system. In addition the hospitals are responsible for the surveillance and reporting of HAI data to the Department using the National Healthcare Safety Network (NHSN) managed by the Centers for Disease Control and Prevention (CDC). The bill also authorizes the Department to release HAI data collected that does not contain personal identifying information, but only if the Department considers the release of the data to be in the public interest.

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

BACKGROUND:

Approximately 27 states have enacted laws that require hospitals to report data related to HAI. Since 2005 the number of states with these laws has increased from five to 27.¹

The Joint Study Committee on Hospital Infection Control and Disclosure was established by the NC General Assembly in 2008. The Committee, in its 2009 Report to the NC General Assembly, recommended implementation of a mandatory, state-operated, statewide HAI surveillance and reporting system.

The Division of Public Health (Division) is currently receiving federal funding that is supporting work in HAI surveillance and prevention. Funding has been provided through the American Recovery and Reinvestment Act. In order to continue its work on HAI surveillance and reporting, the Division will be applying for federal funding from the Affordable Care Act (ACA) through the CDC after December of this year.

S347-SMTE-3(e1) v2

¹ NCSL website: www.ncsl.org/default.aspx?tabid=14084

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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1

SENATE BILL 384*

Short Title: Conforming Changes/Persons W/Disabilities Act. (Public)

Sponsors: Senator Hartsell.

Referred to: Health Care.

March 22, 2011

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA PERSONS WITH DISABILITIES
PROTECTION ACT TO CONFORM WITH FEDERAL CHANGES UNDER THE
AMERICANS WITH DISABILITIES ACT AMENDMENTS ACT OF 2008 (ADAAA).

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 168A-3 reads as rewritten:

"§ 168A-3. Definitions.

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

(1) "Covered governmental entity" means any State department, institution, agency, or any political subdivision of the State or any person that contracts with a State department, institution, agency, or political subdivision of the State for the delivery of public services, including, but not limited to, education, health, social services, recreation, and rehabilitation.

~~(1)~~(1a) "Disabling condition" means any condition or characteristic that renders a person a person with a disability.

~~(1a)~~(1b) "Discriminatory practice" means any practice prohibited by this Chapter.

...
(7a) "Person with a disability" means any person who (i) has a physical or mental impairment which substantially limits one or more major life activities; (ii) has a record of such an impairment; or (iii) is regarded as having such an impairment. As used in this subdivision, the term:

a. "Physical or mental impairment" means (i) any physiological disorder or abnormal condition, cosmetic disfigurement, or anatomical loss, caused by bodily injury, birth defect or illness, ~~affecting one or more of the following body systems:~~a body system, including, but not limited to, neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (ii) any mental disorder, such as mental retardation, organic brain syndrome, mental illness, specific learning disabilities, and other developmental disabilities, but (iii) excludes (A) sexual preferences; (B) active alcoholism or drug addiction or abuse; and (C) any disorder, condition or disfigurement which is temporary in nature-nature, lasting six months or fewer, and leaving no residual impairment. A disorder, condition, or disfigurement that is episodic or in remission is a physical or mental impairment if it would substantially limit a major life activity when active.



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- b. "Major life activities" means ~~functions such as~~functions, including, but not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, eating, sleeping, lifting, bending, standing, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also includes the operation of a major bodily function, including, but not limited to, functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.
- c. "Has a record of such an impairment" means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits major life activities.
- d. "Is regarded as having an impairment" means (i) has a physical or mental impairment that does not substantially limit major life activities but that is treated as constituting such a limitation; (ii) has a physical or mental impairment that substantially limits major life activities because of the attitudes of others; or (iii) has none of the impairments defined in paragraph a. of this subdivision but is treated as having such an impairment.

The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures, such as (i) medication, medical supplies, equipment, or appliances, low-vision devices, which do not include ordinary eyeglasses or contact lenses, prosthetics, including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies; (ii) use of assistive technology; (iii) reasonable accommodations or auxiliary aids or services; or (iv) learned behavioral or adaptive neurological modifications.

...
(10) "Reasonable accommodations" means:

- ...
b. With regard to a place of public ~~accommodations~~accommodations and a covered governmental entity, making reasonable efforts to accommodate the disabling conditions of a person with a disability, including, but not limited to, making facilities accessible to and usable by persons with a disability, redesigning equipment, ~~provide~~providing auxiliary aids and services needed to make aurally and visually delivered materials available, as needed, to individuals with hearing or sight impairments, providing mechanical aids or other assistance, or using alternative accessible locations, provided that reasonable accommodations does not require efforts which would impose an undue hardship on the entity involved.

...."

SECTION 2. G.S. 168A-4 reads as rewritten:

"§ 168A-4. Reasonable accommodation duties.

(a) A qualified person with a disability requesting a reasonable accommodation must apprise the employer, employment agency, labor organization, ~~or~~place of public accommodation~~accommodation~~, or covered governmental entity of his or her disabling condition, submit any necessary medical documentation, make suggestions for such possible accommodations as are known to such person with a disability, and cooperate in any ensuing discussion and evaluation aimed at determining possible or feasible accommodations.

(b) Once a qualified person with a disability has requested an accommodation, or if a potential accommodation is obvious in the circumstances, an employer, employment agency, labor organization or organization, place of public accommodation, or covered governmental entity shall investigate whether there are reasonable accommodations that can be made and make reasonable accommodations as defined in G.S. 168A-3(10)."

SECTION 3. G.S. 168A-7 reads as rewritten:

"§ 168A-7. Discrimination in public service.

(a) It is a discriminatory practice for a State department, institution, or agency, or any political subdivision of the State or any person that contracts with the above for the delivery of public services including but not limited to education, health, social services, recreation, and rehabilitation, covered governmental entity to exclude a qualified person with a disability from participation in or deny the benefits of services, programs, or activities because of a disability or to refuse to provide reasonable accommodations, including auxiliary aids and adaptations services necessary for a known qualified person with a disability to use or benefit from existing public services operated by such entity; provided that the aids and adaptations accommodations do not impose an undue hardship on the entity involved. This subsection includes equivalent services provided via information technology.

(b) A State department, institution, or agency, any political subdivision of the State, and any person that contracts with these entities for the delivery of public services covered governmental entity shall administer its services, programs, and activities in the most integrated setting appropriate to the needs of persons with disabilities."

SECTION 4. G.S. 168A-9 reads as rewritten:

"§ 168A-9. Affirmative defenses.

Any employer may assert affirmative defenses in any action brought under this Chapter. This section shall not create any inference that an employment action which is not listed as an affirmative defense is therefore, by implication, a discriminatory practice, so long as the employment action is not otherwise prohibited by this Chapter. The following is a non-exclusive list of affirmative defenses:

- (1) The failure of the qualified person with a disability to comply with or meet the employer's work rules and policies or performance standards, absent a reasonable accommodation excusing noncompliance, provided that such the person is not held to rules or standards different from other employees without a disability similarly employed;
- (2) The excessive, willful or habitual tardiness or absence of a qualified person with a disability, absent a reasonable accommodation that allows for flexible working hours, provided that the standard used by the employer in determining whether such tardiness or absence is excessive is the same as that applied by the employer to employees without a disability similarly employed; or
- (3) A bona fide seniority or merit system, or a system which measures earnings by quantity or quality of work or production, or differences in location of employment."

SECTION 5. G.S. 168A-10 reads as rewritten:

"§ 168A-10. Retaliation prohibited.

(a) No employer shall discharge, expel, refuse to hire, or otherwise discriminate against any person or applicant for employment, nor shall any employment agency discriminate against any person, nor shall a labor organization discriminate against any member or applicant for membership because such the person has opposed any practice made a discriminatory practice by this Chapter or because he the person has testified, assisted or participated in any manner in proceedings under this Chapter.

1 (b) No entity or person covered under this Chapter shall retaliate against or coerce,
2 intimidate, threaten, or interfere with a person who exercises rights under this Chapter or assists
3 a person in exercising the person's rights under this Chapter."

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



SENATE BILL 384: Conforming Changes/Persons W/Disabilities Act

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: First Edition

Date: March 29, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 384 will amend the North Carolina Persons with Disabilities Protection Act to conform to the federal changes under the Americans with Disabilities Act Amendments of 2008.*

BACKGROUND: Amendments to the Americans with Disabilities Act (ADA) were signed into law on September 25, 2008. These amendments revise the definition of "disability," state that mitigating measures such as assistive devices will have no bearing in determining whether a disability qualifies under law, and clarify coverage of impairments that are episodic or in remission. The amendments had an effective date of January 1, 2009.

BILL ANALYSIS: Senate Bill 384 would add a new definition of "covered governmental entity" that is subject to the NC Persons with Disabilities Protection Act. A covered governmental entity is any State department, institution, agency, or any political subdivision of the State or any person that contracts with those State entities for delivery of public services.

The following ADA-conforming changes are made:

- "Physical or mental impairment" includes a disorder, condition or disfigurement that is episodic or in remission if it would substantially limit a major life activity.
- "Major life activities" include the additional functions of eating, sleeping, lifting, bending, standing, reading, concentrating, thinking, and communicating. Also included is the operation of a major bodily function such as functions of the bowel or bladder or respiratory system.
- Additional language is added to the Act stating that mitigating measures such as assistive devices, assistive technology, reasonable accommodations or auxiliary aids, and learned behavioral or adaptive neurological modifications will not be taken into account when determining whether an impairment substantially limits a major life activity.
- "Reasonable accommodations" include auxiliary aids and services for individuals with hearing or sight impairment.

There are affirmative defenses that an employer may assert if an action is brought under the North Carolina Persons with Disabilities Act. Language is added the two following affirmative defenses:

- Any failure of a qualified person with a disability to comply with employer's work rules or policies, absent a reasonable accommodation excusing noncompliance.
- Any excessive, willful or habitual tardiness by a qualified person with a disability, absent a reasonable accommodation that allows for flexible working hours.

No entity or person covered under this Act is able to retaliate against or coerce or intimidate a person who exercises rights under this Act or who assists a person in exercising those rights.

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

S384-SMTK-8(e1) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 375

Short Title: Facilitate Statewide Health Info. Exchange. (Public)

Sponsors: Senators Stein and Brunstetter.

Referred to: Health Care.

March 21, 2011

A BILL TO BE ENTITLED
AN ACT TO FACILITATE AND REGULATE THE DISCLOSURE OF PROTECTED
HEALTH INFORMATION THROUGH A VOLUNTARY, STATEWIDE HEALTH
INFORMATION EXCHANGE NETWORK.

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 29A.

"North Carolina Health Information Exchange Act.

"§ 90-413.1. Title.

This act shall be known and may be cited as the "North Carolina Health Information
Exchange Act."

"§ 90-413.2. Purpose.

This Article is intended to improve the quality of health care delivery within this State by
facilitating and regulating the use of a voluntary, statewide health information exchange
network for the secure electronic transmission of individually identifiable health information
among health care providers, health plans, and health care clearinghouses in a manner that is
consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and
Security Rule, 45 C.F.R. §§ 160, 164.

"§ 90-413.3. Definitions.

The following definitions apply in this Article:

(1) "Business associate" is as defined in 45 C.F.R. § 160.103.

(2) "Business associate contract" means the documentation required by 45
C.F.R. § 164.502(e)(2) that meets the applicable requirements of 45 C.F.R. §
164.504(e).

(3) "Covered entity" is as defined in 45 C.F.R. § 160.103.

(4) "Disclose" or "disclosure" means the release, transfer, provision of access to,
or divulging in any other manner an individual's protected health information
through the HIE Network.

(5) "Emergency medical condition" means a medical condition manifesting
itself by acute symptoms of sufficient severity, including severe pain, such
that the absence of immediate medical attention could reasonably be
expected to result in (i) placing an individual's health in serious jeopardy, (ii)
serious impairment to an individual's bodily functions, or (iii) serious
dysfunction of any bodily organ or part of an individual.

(6) "HIE Network" means the voluntary, statewide health information exchange
network overseen and administered by the NC HIE.



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- (7) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.
- (8) "Individual" is as defined in 45 C.F.R. § 160.103.
- (9) "North Carolina Health Information Exchange" or "NC HIE" means the nonprofit corporation selected by the Governor to serve as the subrecipient of grant funds from or as the State-designated entity named by the State pursuant to section 3013 of the federal Health Information Technology for Economic and Clinical Health Act, P.L. 111-5, Div. A, Title XIII, section 13001, as amended.
- (10) "Opt out" means an individual's affirmative decision to disallow his or her protected health information maintained by or on behalf of one or more specific covered entities from being disclosed to other covered entities through the HIE Network.
- (11) "Protected health information" is as defined in 45 C.F.R. § 160.103.
- (12) "Public health purposes" means the public health activities and purposes described in 45 C.F.R. § 164.512(b).
- (13) "Research purposes" means research that meets the standard described in 45 C.F.R. § 164.512(i).

"§ 90-413.4. North Carolina Health Information Exchange; requirements.

(a) The NC HIE shall satisfy all of the following requirements:

- (1) Oversee and administer the HIE Network in a manner that ensures all of the following:
- a. Compliance with this Article.
- b. Compliance with HIPAA and any rules adopted under HIPAA, including the Privacy Rule and Security Rule.
- c. Compliance with the terms of any business associate contract the NC HIE enters into with a covered entity participating in the HIE Network.
- d. Notice to the public about the HIE Network, including information and education about the right of individuals on a continuing basis to opt out or rescind a decision to opt out.
- e. Opportunity for all individuals to exercise on a continuing basis the right to opt out or rescind a decision to opt out.
- f. Nondiscriminatory treatment by covered entities of individuals who exercise the right to opt out.
- (2) Develop and enter into written participation agreements with covered entities that utilize the HIE Network. The participation agreements shall specify the terms and conditions governing participation in the HIE Network. The agreement shall also require compliance with policies developed by the NC HIE pursuant to this Article, or pursuant to applicable laws of the state of residence for entities located outside of North Carolina.
- (3) Add, remove, disclose, and access protected health information through the HIE Network in accordance with this Article.
- (4) Enter into a business associate contract with each of the covered entities participating in the HIE Network.
- (5) Grant user rights to the HIE Network to business associates of covered entities participating in the HIE Network (i) at the request of the covered entities and (ii) at the discretion of the NC HIE upon consideration of the business associates' legitimate need for utilizing the HIE Network and privacy and security concerns.
- (6) Facilitate and promote use of the HIE Network by covered entities.

(7) Periodically monitor compliance with this Article by covered entities participating in the HIE Network.

(b) Nothing in this section shall be construed to restrict the NC HIE from exercising any of its corporate powers in a manner that is not inconsistent with this Article.

"§ 90-413.5. Participation by covered entities.

(a) Each covered entity that elects to participate in the HIE Network shall enter into a business associate contract and a written participation agreement with the NC HIE prior to disclosing or accessing any protected health information through the HIE Network.

(b) Each covered entity that elects to participate in the HIE Network may authorize its business associates to disclose or access protected health information on behalf of the covered entity through the HIE Network in accordance with this Article and at the discretion of the NC HIE, as provided in G.S. 90-413.4(5).

(c) Notwithstanding any State law or regulation to the contrary, each covered entity that elects to participate in the HIE Network may disclose an individual's protected health information through the HIE Network (i) to other covered entities for any purpose permitted by HIPAA, unless the individual has exercised the right to opt out and (ii) in order to facilitate the provision of emergency medical treatment to the individual, subject to the requirements set forth in G.S. 90-413.6(e).

(d) Any health care provider who relies in good faith upon any information provided through the NC HIE in the health care provider's treatment of a patient shall not incur criminal or civil liability for damages caused by the inaccurate or incomplete nature of this information.

"§ 90-413.6. Continuing right to opt out; effect of opt out; exception for emergency medical treatment.

(a) Each individual has the right on a continuing basis to opt out or rescind a decision to opt out.

(b) The NC HIE or its designee shall enforce an individual's decision to opt out or rescind an opt out prospectively from the date the NC HIE or its designee receives notice of the individual's decision to opt out or rescind an opt out in the manner prescribed by the NC HIE. An individual's decision to opt out or rescind an opt out does not affect any disclosures made by the NC HIE or covered entities through the HIE Network prior to receipt by the NC HIE or its designee of the individual's notice to opt out or rescind an opt out.

(c) A covered entity may not deny treatment or benefits to an individual because of the individual's decision to opt out. However, nothing in this Article is intended to restrict a treating physician from otherwise appropriately terminating a relationship with a patient in accordance with applicable law and professional ethical standards.

(d) Except as otherwise permitted in subsection (e) of this section and G.S. 90-413.7(a)(3), the protected health information of an individual who has exercised the right to opt out may not be disclosed to covered entities through the HIE Network for any purpose.

(e) The protected health information of an individual who has exercised the right to opt out may be disclosed through the HIE Network in order to facilitate the provision of emergency medical treatment to the individual if all of the following criteria are met:

- (1) The reasonably apparent circumstances indicate to the treating health care provider that (i) the individual has an emergency medical condition, (ii) a meaningful discussion with the individual about whether to rescind a previous decision to opt out is impractical due to the nature of the individual's emergency medical condition, and (iii) information available through the HIE Network could assist in the diagnosis or treatment of the individual's emergency medical condition.

(2) The disclosure through the HIE Network is limited to the covered entities providing diagnosis and treatment of the individual's emergency medical condition.

(3) The circumstances and extent of the disclosure through the HIE Network is recorded electronically in a manner that permits the NC HIE or its designee to periodically audit compliance with this subsection.

"§ 90-413.7. Construction and applicability.

(a) Nothing in this Article shall be construed to do any of the following:

(1) Impair any rights conferred upon an individual under HIPAA, including all of the following rights related to an individual's protected health information:

a. The right to receive a notice of privacy practices.

b. The right to request restriction of use and disclosure.

c. The right of access to inspect and obtain copies.

d. The right to request amendment.

e. The right to request confidential forms of communication.

f. The right to receive an accounting of disclosures.

(2) Authorize the disclosure of protected health information through the HIE Network to the extent that the disclosure is restricted by federal laws or regulations, including the federal drug and alcohol confidentiality regulations set forth in 42 C.F.R. Part 2.

(3) Restrict the disclosure of protected health information through the HIE Network for public health purposes or research purposes, so long as disclosure is permitted by both HIPAA and State law.

(4) Prohibit the NC HIE or any covered entity participating in the HIE Network from maintaining in the NC HIE computer system a copy of the protected health information of an individual who has exercised the right to opt out, as long as the NC HIE does not access, use, or disclose the individual's protected health information for any purpose other than for necessary system maintenance or as required by federal or State law.

(b) This Article applies only to disclosures of protected health information made through the HIE Network. It does not apply to the use or disclosure of protected health information in any context outside of the HIE Network, including the redisclosure of protected health information obtained through the HIE Network.

"§ 90-413.8. Penalties and remedies.

A covered entity that discloses protected health information in violation of this Article is subject to the following:

(1) Any civil penalty or criminal penalty, or both, that may be imposed on the covered entity pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, P.L. 111-5, Div. A, Title XIII, section 13001, as amended, and any regulations adopted under the HITECH Act.

(2) Any civil remedy under the HITECH Act or any regulations adopted under the HITECH Act that is available to the Attorney General or to an individual who has been harmed by a violation of this Article, including damages, penalties, attorneys' fees, and costs.

(3) Disciplinary action by the respective licensing board or regulatory agency with jurisdiction over the covered entity.

(4) Any penalty authorized under Article 2A of Chapter 75 of the General Statutes if the violation of this Article is also a violation of Article 2A of Chapter 75 of the General Statutes.

1 (5) Any other civil or administrative remedy available to a plaintiff by State or
2 federal law or equity."

3 **SECTION 2.** This act becomes effective October 1, 2011.

PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 3-30 TIME: 11 AM

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
¹ Lauren Poythress	Morrisville	Bergen
² Jordan Laughinghouse	mooreville	Forrester
³		
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¹⁰		

Do not add names below the grid.

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

VISITOR REGISTRATION SHEET

Health Committee

3-30-11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
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NAME

FIRM OR AGENCY AND ADDRESS

Zack Moore

Div. of Public Health

Constance D. Jones

Div. of Public Health

LEVI NJORD

DIV. OF PUBLIC HEALTH

Kay Emanuel

Legislative Reporting Services

Paul Kerner, MD

Triangle Orthopaedics

Dr. ALBERT, MD

Bayleth orthopaedic clinic

DAVID W BOONE, MD

NC ORTHOPAEDIC CLINIC

Janine Daxey, MD

Division of Public Health

Brittney Smith

NC A&T SU Social Work Dept.

Jocelia Webster

"

"

Kayla Newman

MSW

Student

UNCC + NC A&T Social Work
Department

Name

Firm / Agency

Caramia Garri

UNC-Greensboro

Calvetta Watlington

UNC-Greensboro

Jacinta Blair

UNC-Greensboro

Andres Mondragon

UNC-Greensboro

Debra

NCHEC

Jennifer Mahan

ISNC

Anna Lisa Bolton

br NC

Bob Heatt

MWC

Kierra Woods

UNC-Greensboro

Kendra Smith

UNC-Greensboro

Abby Emanuelson

NMSS-NC

Caroline Denning

NMSS-NC

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Health Committee

Name of Committee

3-30-11

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NAME	FIRM OR AGENCY AND ADDRESS
BRIGGS WESCHE	A SOUTHERN SEASON, INC
MARILYN MARKEL	A SOUTHERN SEASON
Natosha Knight	UNCG/A&T Social Work
Latoya Alexander	UNCG/ A+T Social work
Christie Chapman	UNCG/A&T social work
Janet Caldwell	UNC-G/A&T Social work
Janet Kanode	UNCW Faculty & Joint Master of Social Work Program - NCAT/ UNCG
Jamie Fuller	UnCG - NCAT Social work
Jasmine Sampson	UNCG/NC A+T Social Work Program
Allison Pappas	Meredith college - SWK Program
Evelyn M. Foust	Division Public Health

Name

Paul Bone

Diane Jones

Firm Agency

Bone & Assoc.

UNC - Greensboro JMSW Program

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Health Committee

3-30-11

Name of Committee

Date

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NAME	FIRM OR AGENCY AND ADDRESS
Emma Topor	Warren Wilson College 701 Warren Wilson Rd., Swannanoa, NC
TINA GORDON	NC Nurses
Loren Bethel	Warren Wilson College
Kristen McQuade	701 Warren Wilson Rd., Swannanoa, NC warren wilson college 701 warren wilson Rd. Swannanoa, NC
Kristi Haff	NCHCFA
Jeff Abner	DAHS-DAHS
Jesse Goodman	DAHS-DAHS
Jill Moore	UNC SDG
Jed Maynard	NCHCFA
BS Miller	Losses cone
Christine / Kim	Wakumol
Erin Hildebrand	CHGR

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Health Committee

3-30-11

Name of Committee

Date

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NAME	FIRM OR AGENCY AND ADDRESS
Dianene Jackson	University North Carolina Greensboro Greensboro, N.C.
Rachel Mitchell	East Carolina University Greenville, NC
LaTarsha Jenkins	East Carolina University Greenville, NC
Nancy Stephens	NC State University Raleigh, NC
J. CRYSTAL JEFFCOAT	NC STATE UNIVERSITY, RALEIGH, NC
Hannah Raines	NC State University Raleigh, NC NASW-NC E
Joyce Thomas	East Carolina University Greenville, NC
Stephanie Lee	East Carolina University Greenville NC
Dana Simpson	Sandra Anderson
Dr. Bill de Araujo	GOLDSBORO ORTHO ASSOC 2808 McLAMB PL NC 27534
OLIVIA DE ARAUJO	"
BEUNDA SKOMMERLIN	RTN
MICHAEL SMITH	PT "

VISITOR REGISTRATION SHEET

Health Committee

3-30-11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
James Roberts	UNCG - IASW
Delilah Stewart	UNCG
John N. Castopou	105 - Am. Heart Assoc
Ann Harris	UNCNA
Mikaela Trank	NEAEC
Matt Wolfe	Parker Poe
Macques O'Neil	Smith Anderson
Denise	WKU
Jennie Bonner-Konors	NC Housing Coalition
Nancy Kelly	Public Group
DAVID BARNES	PS

name	firm or agency
John Bowditch	Astra Zeneca
Matth Leonard	SEARC
Chuck Stone	SEARC
John Morosik	Pricing Group.

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, April 6, 2011

Room 544, LOB

The Senate Committee on Health Care met at 11:00 a.m. on Wednesday, April 6, 2011, in Room 544 of the Legislative Office Building. Sixteen members were present, with Senator Harris Blake presiding.

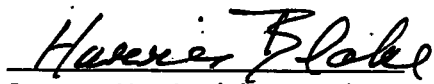
Senator Blake called the meeting to order, welcomed everyone and introduced the Sergeants-at-Arms and Pages assisting with the meeting

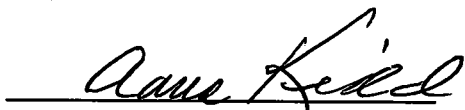
Senator Blake recognized Senator Hartsell to explain SB 433, "Local Human Services Administration." After Senator Hartsell completed his explanation of the bill, Senator Blake asked if anyone from the audience wished to make comments. Several interested parties took the podium and stated their case (see attachments). After everyone had stated their concerns and comments, Senator Blake asked for motions. Senator Berger made a motion for an amendment. Following the amendment, more questions were asked and answered. Motion was made by Senator Berger to pass the bill with his amendment; but the amendment failed.

At this point, Senator Tucker sent forth an amendment. There was more discussion, questions and answers. Senator Rabon made a motion for a favorable report of the amendment which passed. The Committee unanimously voted for an unfavorable report as to the original bill with a favorable report for the PCS.

Senator Blake adjourned the meeting at 11:55 a.m.

Copies of presentations are attached to these minutes.


Senator Harris Blake, Co-Chair


Anna Kidd, Committee Assistant

Anna Kidd (Sen. Blake)

From: Maria Kinnaird (Sen. Bingham)
Sent: Thursday, March 31, 2011 2:53 PM
To: Sen. Fletcher Hartsell, Jr.
Cc: Gerry Johnson (Sen. Hartsell)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wed, 04-06-2011 at 11:00 AM

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 6, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 307	Smart Card Biometrics Against Medicaid Fraud.	Senator Hartsell
SB 433	Local Human Services Administration.	Senator Hartsell
SB 437	Enact First Evaluation Program.	Senator Hartsell
SB 422	DHHS Study of IOM Task Force Recom 3.1.	Senator Bingham
SB 449	Task Force on Fraud Against Older Adults.	Senator Bingham
SB 450	Direct Care Worker Wage and Benefit Study.	Senator Bingham
SB 451	Extend Reporting on Baby Boomer Preparations.	Senator Bingham

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair

Anna Kidd (Sen. Blake)

From: Shawn Parker (Research)
Sent: Thursday, March 31, 2011 12:23 PM
:
:
:
Subject: Anna Kidd (Sen. Blake); Sen. Harris Blake; Sen. Louis Pate; Sen. Stan Bingham
Maria Kinnaird (Sen. Bingham); Edna Pearce (Sen. Pate)
Senate Health Care meeting 4-6-11

Follow Up Flag: Follow up
Flag Status: Flagged

Chairman Blake, Pate, and Bingham

I have confirmed Senator Hartsell's bill for committee and was advised by fellow staff that all 4 COA bills could move without controversy. So if it is your pleasure we can be prepared to hear the following: If we don't get to one of the last bills it can carry over.

If you agree Anna can send the notice accordingly.
Please let me know if you have any questions or concerns.
Shawn

S 0307	Smart Card Biometrics Against Medicaid Fraud	Hartsell
S 0422	DHHS Study Task NCIOm Taks Force Recom 3.1	Bingham
S 0433	Local Human Services Administration	Hartsell
S 0437	Enact First Evaluation Program	Hartsell
S 0449	Task Force on Fraud against Older Adults	Bingham
S 0450	Direct Care Worker Wage and Benefit Study	Bingham
S 0451	Extend Reporting on Baby Boomer Preparations	Bingham

Shawn P. Parker, JD, MPA
Senior Legislative Analyst, Staff Attorney
NC General Assembly, Research Division
545 Legislative Office Building
300 North Salisbury Street
Raleigh, North Carolina 27603-5925
(919) 733-2578 (919) 715-5460 (fax)

SENATE HEALTH CARE COMMITTEE

**Wednesday, April 6, 2011
Room 544 LOB
11:00 AM**

Senator Harris Blake, Presiding

AGENDA

WELCOME AND OPENING REMARKS

BILLS TO BE CONSIDERED

BILL SPONSORS

**SB 307 Smart Card Biometrics Against
Medicaid Fraud.**
SB 433 Local Human Services Administration.
SB 437 Enact First Evaluation Program.
**SB 422 DHHS Study of IOM Task Force
Recom 3.1.**
**SB 449 Task Force on Fraud Against Older
Adults.**
**SB 450 Direct Care Worker Wage and Benefit
Study.**
**SB 451 Extend Reporting on Baby Boomer
Preparations.**

Senator Hartsell

Senator Hartsell
Senator Hartsell
Senator Bingham

Senator Bingham

Senator Bingham

Senator Bingham

OTHER BUSINESS

ADJOURNMENT

BILL ACTION WORKSHEET FOR COMMITTEE MEETINGS

Committee: Senate Health Care
 Meeting Date: 4-6-11 Chair: Sen. BLAKE Clerk: ANNA RALPH

ACTION ON BILLS

Bill	<u>S.B. - 422</u>	Sponsor	<u>Burgham</u>
Favorable	_____	Motion by	_____
Unfavorable	_____	Motion by	_____
Amended	_____	Motion by	_____
Comm. Sub.	_____	Motion by	_____
Original Bill	<u>PA LLED</u>	Motion by	_____
Re-referred	_____	Motion by	_____
Other Action	_____		

Bill	<u>S.B. - 433</u>	Sponsor	<u>Hartsell</u>
Favorable	_____	Motion by	_____
Unfavorable	_____	Motion by	_____
Amended	_____	Motion by	_____
Comm. Sub.	_____	Motion by	_____
Original Bill	_____	Motion by	_____
Re-referred	_____	Motion by	_____
Other Action	_____		

Bill	_____	Sponsor	_____
Favorable	_____	Motion by	_____
Unfavorable	_____	Motion by	_____
Amended	_____	Motion by	_____
Comm. Sub.	_____	Motion by	_____
Original Bill	_____	Motion by	_____
Re-referred	_____	Motion by	_____
Other Action	_____		

Bill	_____	Sponsor	_____
Favorable	_____	Motion by	_____
Unfavorable	_____	Motion by	_____
Amended	_____	Motion by	_____
Comm. Sub.	_____	Motion by	_____
Original Bill	_____	Motion by	_____
Re-referred	_____	Motion by	_____
Other Action	_____		

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, April 06, 2011

Senator BLAKE,

submits the following with recommendations as to passage:

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

S.B.	433	Local Human Services Administration.	
		Draft Number:	PCS 55215
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SB 433- Sen. Hartsell

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____

DATE _____

S. B. No. _____

Amendment No. I

(to be filled in by
Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)

Sen.)

Berger

1 moves to amend the bill on page 3, line 36-38

2 () WHICH CHANGES THE TITLE

3 by revising the lines to read:

4 "Subject to personnel policies and

5 ordinance ~~only~~ and are ~~not~~ subject

6 to the provisions of the State Personnel Act."

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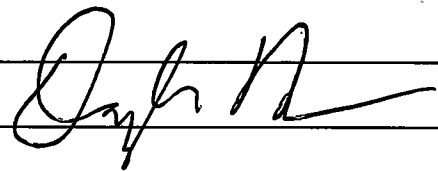
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SIGNED



ADOPTED _____ FAILED _____ TABLED _____



**NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 433***

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

S433-ASQ-24 [v.1]

Page 1 of 2

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date , 2011

Senator _____

1 moves to amend the bill on page 4, line 15 by rewriting the line to read:

2 "SECTION 2. G.S.153A-76 reads as rewritten:

3 '**§ 153A-76. Board of commissioners to organize county government.**

4 The board of commissioners may create, change, abolish, and consolidate offices, positions,
5 departments, boards, commissions, and agencies of the county government, may impose ex
6 officio the duties of more than one office on a single officer, may change the composition and
7 manner of selection of boards, commissions, and agencies, and may generally organize and
8 reorganize the county government in order to promote orderly and efficient administration of
9 county affairs, subject to the following limitations:

- 10 (1) The board may not abolish an office, position, department, board,
11 commission, or agency established or required by law.
12 (2) The board may not combine offices or confer certain duties on the same
13 officer when this action is specifically forbidden by law.
14 (3) The board may not discontinue or assign elsewhere a function or duty
15 assigned by law to a particular office, position, department, board,
16 commission, or agency.
17 (4) The board may not change the composition or manner of selection of a local
18 board of education, ~~the board of health, the board of social services,~~ the
19 board of elections, or the board of alcoholic beverage control.'

20 **SECTION 3. G.S. 126-5(a) reads as rewritten:**

21 '(a) The provisions of this Chapter shall apply to:

- 22 (1) All State employees not herein exempt, and
23 (2) All employees of the following local entities:
24 a. Area mental health, developmental disabilities, and substance abuse
25 authorities.
26 b. Local social services departments.
27 c. County health departments and district health departments.
28 d. Local emergency management agencies that receive federal
29 grant-in-aid funds.

30 ~~An employee of a consolidated county human services agency created~~
31 ~~pursuant to G.S. 153A-77(b) is not considered an employee of an entity~~
32 ~~listed in this subdivision.~~



* S 4 3 3 - A S Q - 2 4 - V - 1 *

NORTH CAROLINA GENERAL ASSEMBLY

AMENDMENT

Senate Bill 433*

AMENDMENT NO. _____

(to be filled in by

Principal Clerk)

S433-ASQ-24 [v.1]

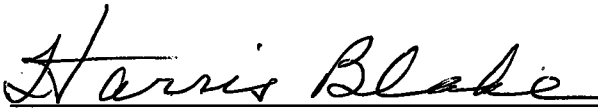
Page 2 of 2

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(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine.'

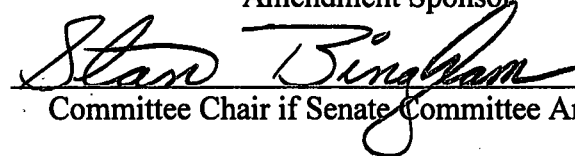
SECTION 4. This act is effective when it becomes law."

SIGNED



Amendment Sponsor

SIGNED



Committee Chair if Senate Committee Amendment

ADOPTED _____

FAILED _____

TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 433*
PROPOSED COMMITTEE SUBSTITUTE S433-PCS55215-SQ-7

Short Title: Local Human Services Administration.

(Public)

Sponsors:

Referred to:

March 29, 2011

1 A BILL TO BE ENTITLED
2 AN ACT CONCERNING ADMINISTRATION OF HUMAN SERVICES IN COUNTIES
3 THAT HAVE ELECTED TO CONSOLIDATE THOSE SERVICES DIRECTLY EITHER
4 UNDER THE COUNTY OR UNDER A CONSOLIDATED HUMAN SERVICE BOARD,
5 AND TO MAKE THAT STATUTE STATEWIDE IN APPLICABILITY.

6 The General Assembly of North Carolina enacts:

7 SECTION 1. G.S. 153A-77 reads as rewritten:

8 "§ 153A-77. Authority of boards of commissioners in certain counties over commissions,
9 boards, agencies, etc.

10 (a) In the exercise of its jurisdiction over commissions, boards and agencies, the board
11 of county commissioners may assume direct control of any activities theretofore conducted by
12 or through any commission, board or agency by the adoption of a resolution assuming and
13 conferring upon the board of county commissioners all powers, responsibilities and duties of
14 any such commission, board or agency. This subsection shall apply to the board of health, the
15 social services board, area mental health, developmental disabilities, and substance abuse area
16 board and any other commission, board or agency appointed by the board of county
17 commissioners or acting under and pursuant to authority of the board of county commissioners
18 of said county. A board of county commissioners exercising the power and authority under this
19 subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the
20 board through the imposition of civil penalties. If a public health rule adopted by a board of
21 county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its
22 violation a misdemeanor shall not be applicable to that public health rule unless the rule states
23 that a violation of the rule is a misdemeanor. The board of county commissioners may exercise
24 the power and authority herein conferred only after a public hearing held by said board
25 pursuant to 30 days' notice of said public hearing given in a newspaper having general
26 circulation in said county.

27 The board of county commissioners may also appoint advisory boards, committees,
28 councils and agencies composed of qualified and interested county residents to study, interpret
29 and develop community support and cooperation in activities conducted by or under the
30 authority of the board of county commissioners of said county.

31 (b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board
32 of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

33 (1) Consolidate the provision of human services in the county under the direct
34 control of a human services director appointed and supervised by the county



* S 4 3 3 - P C S 5 5 2 1 5 - S Q - 7 *

- 1 manager or by the consolidated human services board under subdivision (2)
2 of this subsection, in accordance with subsection (e) of this section;
3 (2) Create a consolidated human services board having the powers conferred by
4 subsection (c) of this section;
5 (3) Create a consolidated county human services agency having the authority to
6 carry out the functions of the local health department, the county department
7 of social services, and the area mental health, developmental disabilities, and
8 substance abuse services authority; and
9 (4) Assign other county human services functions to be performed by the
10 consolidated human services agency under the direction of the human
11 services director, with policy-making authority granted to the consolidated
12 human services board as determined by the board of county commissioners.

13 (c) A consolidated human services board appointed by the board of county
14 commissioners shall serve as the policy-making, rule-making, and administrative board of the
15 consolidated human services agency. The consolidated human services board shall be
16 composed of no more than 25 members. The composition of the board shall reasonably reflect
17 the population makeup of the county and shall include:

- 18 (1) Eight persons who are consumers of human services, public advocates, or
19 family members of clients of the consolidated human services agency,
20 including: one person with mental illness, one person with a developmental
21 disability, one person in recovery from substance abuse, one family member
22 of a person with mental illness, one family member of a person with a
23 developmental disability, one family member of a person with a substance
24 abuse problem, and two consumers of other human services.
25 (2) Eight persons who are professionals, each with qualifications in one of these
26 categories: one psychologist, one pharmacist, one engineer, one dentist, one
27 optometrist, one veterinarian, one social worker, and one registered nurse.
28 (3) Two physicians licensed to practice medicine in this State, one of whom
29 shall be a psychiatrist.
30 (4) One member of the board of county commissioners.
31 (5) Other persons, including members of the general public representing various
32 occupations.

33 The board of county commissioners may elect to appoint a member of the consolidated
34 human services board to fill concurrently more than one category of membership if the member
35 has the qualifications or attributes of more than one category of membership.

36 All members of the consolidated human services board shall be residents of the county. The
37 members of the board shall serve four-year terms. No member may serve more than two
38 consecutive four-year terms. The county commissioner member shall serve only as long as the
39 member is a county commissioner.

40 The initial board shall be appointed by the board of county commissioners upon the
41 recommendation of a nominating committee comprised of members of the preconsolidation
42 board of health, social services board, and area mental health, developmental disabilities, and
43 substance abuse services board. In order to establish a uniform staggered term structure for the
44 board, a member may be appointed for less than a four-year term. After the subsequent
45 establishment of the board, its board shall be appointed by the board of county commissioners
46 from nominees presented by the human services board. Vacancies shall be filled for any
47 unexpired portion of a term.

48 A chairperson shall be elected annually by the members of the consolidated human services
49 board. A majority of the members shall constitute a quorum. A member may be removed from
50 office by the county board of commissioners for (i) commission of a felony or other crime
51 involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii)

1 violation of a written policy adopted by the county board of commissioners; (iv) habitual
2 failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi)
3 failure to maintain qualifications for appointment required under this subsection. A board
4 member may be removed only after the member has been given written notice of the basis for
5 removal and has had the opportunity to respond.

6 A member may receive a per diem in an amount established by the county board of
7 commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy
8 set by the county board of commissioners. The board shall meet at least quarterly. The
9 chairperson or three of the members may call a special meeting.

10 (d) The consolidated human services board shall have authority to:

- 11 (1) Set fees for departmental services based upon recommendations of the
12 human services director. Fees set under this subdivision are subject to the
13 same restrictions on amount and scope that would apply if the fees were set
14 by a county board of health, a county board of social services, or a mental
15 health, developmental disabilities, and substance abuse area authority.
- 16 (2) Assure compliance with laws related to State and federal programs.
- 17 (3) Recommend creation of local human services programs.
- 18 (4) Adopt local health regulations and participate in enforcement appeals of
19 local regulations.
- 20 (5) Perform regulatory health functions required by State law.
- 21 (6) Act as coordinator or agent of the State to the extent required by State or
22 federal law.
- 23 (7) Plan and recommend a consolidated human services budget.
- 24 (8) Conduct audits and reviews of human services programs, including quality
25 assurance activities, as required by State and federal law or as may otherwise
26 be necessary periodically.
- 27 (9) Advise local officials through the county manager.
- 28 (10) Perform public relations and advocacy functions.
- 29 (11) Protect the public health to the extent required by law.
- 30 (12) Perform comprehensive mental health services planning.
- 31 (13) Develop dispute resolution procedures for human services contractors and
32 clients and public advocates, subject to applicable State and federal dispute
33 resolution procedures for human services programs, when applicable.

34 Except as otherwise provided, the consolidated human services board shall have the powers
35 and duties conferred by law upon a board of health, a social services board, and an area mental
36 health, developmental disabilities, and substance abuse services board.

37 Local employees who serve as staff of a consolidated county human services agency are
38 subject to county personnel policies and ordinances only and are not subject to the provisions
39 of the State Personnel Act. Act, unless the county board of commissioners elects to subject the
40 local employees to the provisions of that Act.

41 (e) The human services director of a consolidated county human services agency shall
42 be appointed and dismissed by the county manager with the advice and consent of the
43 consolidated human services ~~board.~~ board, unless the county board of commissioners elects to
44 have the human services director appointed and dismissed by the consolidated human services
45 board. The human services director shall report directly to the county ~~manager.~~ manager, unless
46 the county board of commissioners elects to have the human services director appointed and
47 supervised by the consolidated human services board. The human services director shall:

- 48 (1) Appoint staff of the consolidated human services agency with the county
49 manager's ~~approval.~~ approval, unless the county board of commissioners
50 elects to have the human services director appointed and supervised by the
51 consolidated human services board.

- 1 (2) Administer State human services programs.
- 2 (3) Administer human services programs of the local board of county
- 3 commissioners.
- 4 (4) Act as secretary and staff to the consolidated human services board under the
- 5 direction of the county manager.
- 6 (5) Plan the budget of the consolidated human services agency.
- 7 (6) Advise the board of county commissioners through the county manager.
- 8 (7) Perform regulatory functions of investigation and enforcement of State and
- 9 local health regulations, as required by State law.
- 10 (8) Act as an agent of and liaison to the State, to the extent required by law.

11 Except as otherwise provided by law, the human services director or the director's designee
12 shall have the same powers and duties as a social services director, a local health director, and a
13 director of an area mental health, developmental disabilities, and substance abuse services
14 authority.

15 ~~(f) This section applies to counties with a population in excess of 425,000."~~

16 **SECTION 2. G.S. 153A-76 reads as rewritten:**

17 **"§ 153A-76. Board of commissioners to organize county government.**

18 The board of commissioners may create, change, abolish, and consolidate offices, positions,
19 departments, boards, commissions, and agencies of the county government, may impose ex
20 officio the duties of more than one office on a single officer, may change the composition and
21 manner of selection of boards, commissions, and agencies, and may generally organize and
22 reorganize the county government in order to promote orderly and efficient administration of
23 county affairs, subject to the following limitations:

- 24 (1) The board may not abolish an office, position, department, board,
- 25 commission, or agency established or required by law.
- 26 (2) The board may not combine offices or confer certain duties on the same
- 27 officer when this action is specifically forbidden by law.
- 28 (3) The board may not discontinue or assign elsewhere a function or duty
- 29 assigned by law to a particular office, position, department, board,
- 30 commission, or agency.
- 31 (4) The board may not change the composition or manner of selection of a local
- 32 board of education, ~~the board of health, the board of social services, the~~
- 33 ~~board of elections, or the board of alcoholic beverage control."~~

34 **SECTION 3. G.S. 126-5(a) reads as rewritten:**

35 **"(a) The provisions of this Chapter shall apply to:**

- 36 (1) All State employees not herein exempt, and
- 37 (2) All employees of the following local entities:
 - 38 a. Area mental health, developmental disabilities, and substance abuse
 - 39 authorities.
 - 40 b. Local social services departments.
 - 41 c. County health departments and district health departments.
 - 42 d. Local emergency management agencies that receive federal
 - 43 grant-in-aid funds.

44 ~~An employee of a consolidated county human services agency created pursuant to~~
45 ~~G.S. 153A-77(b) is not considered an employee of an entity listed in this~~
46 ~~subdivision.~~

- 47 (3) County employees not included under subdivision (2) of this subsection as
- 48 the several boards of county commissioners may from time to time
- 49 determine."

50 **SECTION 4. This act is effective when it becomes law.**

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 433*

Short Title: Local Human Services Administration.

(Public)

Sponsors: Senator Hartsell.

Referred to: Health Care.

March 29, 2011

A BILL TO BE ENTITLED

AN ACT CONCERNING ADMINISTRATION OF HUMAN SERVICES IN COUNTIES
THAT HAVE ELECTED TO CONSOLIDATE THOSE SERVICES DIRECTLY EITHER
UNDER THE COUNTY OR UNDER A CONSOLIDATED HUMAN SERVICE BOARD,
AND TO MAKE THAT STATUTE STATEWIDE IN APPLICABILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 153A-77 reads as rewritten:

**"§ 153A-77. Authority of boards of commissioners in certain counties over commissions,
boards, agencies, etc.**

(a) In the exercise of its jurisdiction over commissions, boards and agencies, the board of county commissioners may assume direct control of any activities theretofore conducted by or through any commission, board or agency by the adoption of a resolution assuming and conferring upon the board of county commissioners all powers, responsibilities and duties of any such commission, board or agency. This subsection shall apply to the board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board and any other commission, board or agency appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners of said county. A board of county commissioners exercising the power and authority under this subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the board through the imposition of civil penalties. If a public health rule adopted by a board of county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its violation a misdemeanor shall not be applicable to that public health rule unless the rule states that a violation of the rule is a misdemeanor. The board of county commissioners may exercise the power and authority herein conferred only after a public hearing held by said board pursuant to 30 days' notice of said public hearing given in a newspaper having general circulation in said county.

The board of county commissioners may also appoint advisory boards, committees, councils and agencies composed of qualified and interested county residents to study, interpret and develop community support and cooperation in activities conducted by or under the authority of the board of county commissioners of said county.

(b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

- (1) Consolidate the provision of human services in the county under the direct control of a human services director appointed and supervised by the county manager or by the consolidated human services board under subdivision (2) of this subsection, in accordance with subsection (e) of this section;



- (2) Create a consolidated human services board having the powers conferred by subsection (c) of this section;
- (3) Create a consolidated county human services agency having the authority to carry out the functions of the local health department, the county department of social services, and the area mental health, developmental disabilities, and substance abuse services authority; and
- (4) Assign other county human services functions to be performed by the consolidated human services agency under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

(c) A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making, and administrative board of the consolidated human services agency. The consolidated human services board shall be composed of no more than 25 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

- (1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.
- (2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.
- (3) Two physicians licensed to practice medicine in this State, one of whom shall be a psychiatrist.
- (4) One member of the board of county commissioners.
- (5) Other persons, including members of the general public representing various occupations.

The board of county commissioners may elect to appoint a member of the consolidated human services board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

All members of the consolidated human services board shall be residents of the county. The members of the board shall serve four-year terms. No member may serve more than two consecutive four-year terms. The county commissioner member shall serve only as long as the member is a county commissioner.

The initial board shall be appointed by the board of county commissioners upon the recommendation of a nominating committee comprised of members of the preconsolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a four-year term. After the subsequent establishment of the board, its board shall be appointed by the board of county commissioners from nominees presented by the human services board. Vacancies shall be filled for any unexpired portion of a term.

A chairperson shall be elected annually by the members of the consolidated human services board. A majority of the members shall constitute a quorum. A member may be removed from office by the county board of commissioners for (i) commission of a felony or other crime involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii) violation of a written policy adopted by the county board of commissioners; (iv) habitual failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi)

1 failure to maintain qualifications for appointment required under this subsection. A board
2 member may be removed only after the member has been given written notice of the basis for
3 removal and has had the opportunity to respond.

4 A member may receive a per diem in an amount established by the county board of
5 commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy
6 set by the county board of commissioners. The board shall meet at least quarterly. The
7 chairperson or three of the members may call a special meeting.

8 (d) The consolidated human services board shall have authority to:

- 9 (1) Set fees for departmental services based upon recommendations of the
10 human services director. Fees set under this subdivision are subject to the
11 same restrictions on amount and scope that would apply if the fees were set
12 by a county board of health, a county board of social services, or a mental
13 health, developmental disabilities, and substance abuse area authority.
- 14 (2) Assure compliance with laws related to State and federal programs.
- 15 (3) Recommend creation of local human services programs.
- 16 (4) Adopt local health regulations and participate in enforcement appeals of
17 local regulations.
- 18 (5) Perform regulatory health functions required by State law.
- 19 (6) Act as coordinator or agent of the State to the extent required by State or
20 federal law.
- 21 (7) Plan and recommend a consolidated human services budget.
- 22 (8) Conduct audits and reviews of human services programs, including quality
23 assurance activities, as required by State and federal law or as may otherwise
24 be necessary periodically.
- 25 (9) Advise local officials through the county manager.
- 26 (10) Perform public relations and advocacy functions.
- 27 (11) Protect the public health to the extent required by law.
- 28 (12) Perform comprehensive mental health services planning.
- 29 (13) Develop dispute resolution procedures for human services contractors and
30 clients and public advocates, subject to applicable State and federal dispute
31 resolution procedures for human services programs, when applicable.

32 Except as otherwise provided, the consolidated human services board shall have the powers
33 and duties conferred by law upon a board of health, a social services board, and an area mental
34 health, developmental disabilities, and substance abuse services board.

35 Local employees who serve as staff of a consolidated county human services agency are
36 subject to county personnel policies and ordinances only and are not subject to the provisions
37 of the State Personnel Act. Act, unless the county board of commissioners elects to subject the
38 local employees to the provisions of that act.

39 (e) The human services director of a consolidated county human services agency shall
40 be appointed and dismissed by the county manager with the advice and consent of the
41 consolidated human services ~~board.~~ board, unless the county board of commissioners elects to
42 have the human services director appointed and dismissed by the consolidated human services
43 board. The human services director shall report directly to the county ~~manager.~~ manager, unless
44 the county board of commissioners elects to have the human services director appointed and
45 supervised by the consolidated human services board. The human services director shall:

- 46 (1) Appoint staff of the consolidated human services agency with the county
47 manager's ~~approval.~~ approval, unless the county board of commissioners
48 elects to have the human services director appointed and supervised by the
49 consolidated human services board.
- 50 (2) Administer State human services programs.

- (3) Administer human services programs of the local board of county commissioners.
- (4) Act as secretary and staff to the consolidated human services board under the direction of the county manager.
- (5) Plan the budget of the consolidated human services agency.
- (6) Advise the board of county commissioners through the county manager.
- (7) Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.
- (8) Act as an agent of and liaison to the State, to the extent required by law.

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as a social services director, a local health director, and a director of an area mental health, developmental disabilities, and substance abuse services authority.

(f) ~~This section applies to counties with a population in excess of 425,000."~~

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

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

S

1

SENATE BILL 422*

Short Title: DHHS Study of IOM Task Force Recom 3.1. (Public)

Sponsors: Senators Bingham; Allran, Atwater, D. Berger, Brown, Clary, Daniel, Dannelly, Forrester, Harrington, Kinnaird, Mansfield, McKissick, Preston, Rabon, Robinson, Stevens, Tillman, Tucker, Vaughan, Walters, and White.

Referred to: Health Care.

March 28, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY RECOMMENDATION 3.1 FROM THE NORTH CAROLINA INSTITUTE OF MEDICINE TASK FORCE ON THE CO-LOCATION OF DIFFERENT POPULATIONS IN ADULT CARE HOMES TO ASSESS THE FEASIBILITY AND IMPLEMENTATION TIME LINE OF A PILOT PROGRAM AIMED AT TRANSITIONING ADULT CARE HOME RESIDENTS TO INDEPENDENT COMMUNITY-BASED HOUSING, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services shall study Recommendation 3.1 from the North Carolina Institute of Medicine Task Force on the Co-Location of Different Populations in Adult Care Homes. The recommendation suggests that the Department develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who are in an adult or family care home and who want to move back into independent supported housing. The Department shall, but is not limited to, evaluate and report on the elements below that are contained in the recommendation.

- (1) The feasibility, fiscal implication, and appropriate timing of the submission of a Medicaid 1915(i) State plan amendment or 1915(c) Home and Community-Based Services waiver to support individuals living in adult or family care homes for 90 or more days who would like to move back to more independent living arrangements.
- (2) The feasibility and cost of developing and implementing a process to evaluate residents of adult care homes to determine whether they can live independently in the community with services, supports, counseling, and transition services.
- (3) The policy implications, impact on current programs, and cost of developing and implementing an additional Special Assistance program option that would be similar to the existing Special Assistance in-home program but exempt from the limits established in S.L. 2007-323. The Department should explore whether this program could be targeted to address concerns the Task Force raised on co-location.
- (4) A time line for implementing the pilot with all of the above elements in place, or a time line for phased implementation of the pilot. This time line



* S 4 2 2 - V - 1 *

1 shall include evaluation of the pilot as described in the Task Force
2 recommendation.

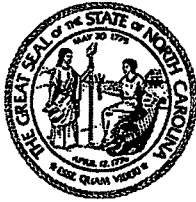
3 (5) The fiscal requirements necessary to provide technical assistance to adult
4 care homes interested in creating financially viable models to support people
5 living more independently as recommended by the Task Force.

6 (6) The existence of statutory and regulatory barriers to independent living for
7 people with disabilities.

8 (7) The goal and intended outcome of this pilot program.

9 **SECTION 1.(b)** On or before October 1, 2012, the Department shall report on the
10 elements outlined in this section to the North Carolina Study Commission on Aging and the
11 Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and
12 Substance Abuse Services.

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



SENATE BILL 422: DHHS Study of IOM Task Force Recom 3.1

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: First Edition

Date: April 5, 2011
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *Senate Bill 422 requires the Department of Health and Human Services to study and report on the feasibility of implementing a recommendation from the Institute of Medicine to transition adult care home residents to independent community-based housing. This bill is a recommendation from the NC Study Commission on Aging.*

BILL ANALYSIS: Senate Bill 422 requires the Department of Health and Human Services to study Recommendation 3.1 from the Institute of Medicine's Task Force on the Co-Location of Different Populations in Adult Care Homes. The bill requires the Department to evaluate and report on the following elements:

- (1) The feasibility, fiscal implication, and appropriate timing of the submission of a Medicaid 1915(i) State plan amendment or 1915(c) Home and Community-Based Services waiver to support individuals living in adult or family care homes for 90 or more days who would like to move back to more independent living arrangements.
- (2) The feasibility and cost of developing and implementing a process to evaluate residents of adult care homes to determine whether they can live independently in the community with services, supports, counseling, and transition services.
- (3) The policy implications, impact on current programs, and cost of developing and implementing an additional Special Assistance program option that would be similar to the existing Special Assistance in-home program but exempt from the limits established in S.L. 2007-323.
- (4) A time line for implementing the pilot.
- (5) The fiscal requirements necessary to provide technical assistance to adult care homes interested in creating financially viable models to support people living more independently as recommended by the Task Force.
- (6) The existence of statutory and regulatory barriers to independent living for people with disabilities.
- (7) The goal and intended outcome of this pilot program.

The Department is required to report the results of this study on or before October 1, 2012, to the NC Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services.

EFFECTIVE DATE: Senate Bill 422 would become effective when it becomes law.

BACKGROUND: S.L. 2009-451, Section 10.78ff(3), required the NC Institute of Medicine (IOM) to study short term and long term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons diagnosed with a mental illness. The NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes met and released a report in January 2011. Recommendation 3.1 requires the Department of Health and Human Services to develop a pilot program to evaluate the costs, quality, consumer satisfaction and patient outcomes of a program that supports individuals who want to move to independent supported housing. (Recommendation 3.1 provided on reverse side.)

Senate Bill 422

Page 2

The NC Study Commission on Aging supports the Institute of Medicine's recommendations, but found there may be some complications with immediate implementation of this IOM recommendation. Therefore, the Study Commission on Aging recommended DHHS study the feasibility of the recommendation and develop a timeline for possible implementation of the recommendation.

NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes Recommendation 3.1: Pilot Program (PRIORITY RECOMMENDATION)

The North Carolina Department of Health and Human Services (DHHS) should develop a pilot program to evaluate the costs, quality, consumer satisfaction, and patient outcomes of a program that supports individuals who would otherwise be in an adult or family care home and who want to move back into independent supported housing. As part of this, DHHS should:

- a) Submit a Medicaid 1915(i) state plan amendment or 1915(c) HCBS waiver to support individuals living in adult or family care homes (ACH) for 90 or more days who would like to move back to more independent living arrangements. The 1915(i) state plan amendment should be modeled after the state's Money Follows the Person initiative for people in nursing facilities. The Medicaid 1915(i) state plan amendment should provide home and community-based services, including, but not limited to, personal care services, adult day care, and case management, and should pay for reasonable one-time transitional costs, including but not limited to security deposits, first month rent, or home modification.
- b) DHHS should develop a process to evaluate people living in ACHs to determine whether people can appropriately live independently in the community with services and supports, and should provide counseling and transition services to appropriate individuals who want to move to more independent living arrangements.
- c) The pilot program should initially be limited to 1,000 individuals who want to, and can appropriately, move to more independent living arrangements with services and supports. Individuals who move out of an ACH should continue to receive the same level of State-County Special Assistance (SA) payment in the community as they were receiving in the ACH. These SA in-home payments should be exempt from the SA in-home limits established as part of Session Law 2007-323.
- d) DHHS should conduct an evaluation to examine costs, quality, individual satisfaction, and patient outcomes of this demonstration in supporting people with disabilities and the frail elderly who would otherwise need ACH level of care to live more independently in the community. The results of the evaluation should be shared with the appropriate legislative committees that address the needs of older adults and of people with mental illness, intellectual and developmental disabilities, and addiction disorders no later than fall 2013 and annually thereafter. If the program is found to be successful, the North Carolina General Assembly should implement the program statewide both for individuals who are residing in ACHs and for those who have not yet entered an ACH but who meet the level of need criteria.
- e) The North Carolina General Assembly should appropriate \$100,000 nonrecurring funds in state fiscal years 2012-2014 to the North Carolina Department of Health and Human Services to provide technical assistance to help interested ACHs create financially viable models that support people to live more independently in the community, such as, but not limited to, multiunit supported housing, recovery-based scattered housing, transitional housing, and adult day care. DHHS should strive to work with rural, urban, large, and small ACH facilities.
- f) DHHS should continue its work to remove statutory and regulatory barriers to independent living options for people with disabilities who receive services in the community.

Good morning!

I am Glenn Osborne, I am the Director of the Wilson County Department Social Services.

This bill was written for large metropolitan counties. It was written first for Mecklenburg and then amended for Wake. It certainly is not my intent to shed any negative reflection upon those two wonderful NC Counties. I am sure they both have gone about their human services consolidations with high integrity and with the right purpose in mind. But surely, you would agree those two counties are not representative of the vast majority of North Carolina Counties.

This bill creates the option of eliminating the local DSS boards and either the county commissioners serve in that capacity or a consolidated board be created. However, the consolidated board structure as defined in this bill would be nearly impossible to construct in a small rural county. We believe eliminating the citizen board and having the county board of commissioners serve in this capacity would be an even larger mistake in small counties. County Commissions already have packed agendas and would not have the time to meet regularly with a human services director for two hours a month to review social services department performance. County Managers serve the interests of the county commissioners and certainly citizen involvement in governance of their human services agencies is lost if managers, or just one individual, serves in this capacity.

We believe the current social services governance structure is working well and does not need changing. We urge you to vote no on this bill today. However, I believe we must always be open to constructive change and I for one am open to working with you to see if a substitute bill can be crafted that preserves the insulation in our current governance structure and prevents inappropriate political influences, cronyism and unethical practices in a local governance structure yet achieves the goals of greater administrative efficiency and cost savings to taxpayers. Allow us to work with you on a governance structure that will work just as well for small counties as metropolitan counties.

Each of you ran for office back home in your counties on a platform. My guess is a part of your platform included to work for a transparent and ethical government. If so I ask you to honor that pledge to your constituents by voting no on this bill. And if you are still not convinced ask yourself these questions: does this bill insure fairness, honesty, transparency and high ethical standards in how it would be conducted by all local governments? Could this bill be used in a manner in which it is not intended? Could it be used to achieve a political purpose such as exerting political influence and unethical practices for all the wrong reasons? If the answer to any of those questions are yes and I believe yes is the answer to all of them, then I ask you to vote consistent to the promise you have made to the people of NC, vote against political cronyism, influence and unethical practices and for maintaining an apolitical governance structure for the people of North Carolina.

- In DSS for 22 years – Director for 11 years.
- My sole concern is about the integrity of the work we do.
- In Social Services I have daily calls from clients, family members, foster parents, schools, court officials, law enforcement officials over neglect, abuse, adoptions, guardianships, Medicaid, food assistance and help with utilities and rent.
- When a decision is different than they would like we are sometimes called incompetent, uncaring, sometimes even lazy
- All of these situations are very emotional in nature and the individuals involved when denied what they think should occur call County Commissioners, County Managers, Social Service Board members to complain
- Senate Bill 433 would politicize the decision making in all of these crucial, life threatening issues we deal with 24 hours a day, 7 days per week.
- It could result in employees making decisions on the fear of angering a county commissioner or other politically influential person and losing their job rather than what is in the best interest of the clients we serve.
- Children could be in danger!
- The elderly could be vulnerable!
- The Social Service boards with their appointments by the County Commissioners, the Governor and Social Services Board provides balance so all levels of government have input into the policies and operations of local county Departments of Social Services.
- While this might not happen in every county, the elimination of Social Service Boards and coverage under the state personnel act would make it possible for these things to happen.
- The potential for harm to the clients we serve outweighs any potential benefits of this legislation.

Thank you for considering this perspective!

Susan G. Osborne, Director, Alamance County Department of Social Services

S-433

CONSOLIDATION OF NC HUMAN SERVICES ISSUES:

POINT PAPERS

NORTH CAROLINA GENERAL ASSEMBLY

SENATE HEALTH CARE COMMITTEE

APRIL 6, 2011

POINT PAPER – CONSOLIDATION OF NC HUMAN SERVICES

RE: Senate 433/H 580: Local Human Services Administration.

S 433 Assigned to the Sen. Health Com. – Scheduled For Wed – Apr 6 in LOB Rm. 544 at 11:00 a.m.

PURPOSE: The purpose of this paper is to present concerns and express a point of view shared by almost all NC Departments of Social Services Directors, Health Department Directors, the NC Social Services Commission & the NC Social Services Association that adoption of S 433 and H 580 will disestablish and dismantle a bi-partisan, unified and jointly shared responsibility to provide Human Services in a professional and cost-effective manner.

FACTS:

- S 433/H 580 directly and significantly changes the NC Human Services delivery system established via N.C.G.S. 153-77, Authority of boards of commissioners in certain counties over commissions, boards, agencies, etc., which steadfastly upholds governance provisions of federal and state law programs.
- Existing law provides statutory oversight/control of Social Services and Health Departments via their respective Boards with jointly established membership representing federal, state and county interests.
- S 433/H 580 seeks, at county option, to place direct program supervision of county Departments of Social Services, county/regional Health Departments and county/regional Mental Health Agencies under the County Manager at the sole discretion of the county board of commissioners. Additionally, it:
 1. Eliminates, at the county board of commissioner discretion, the existing Social Services Board, the Health Department Board (many are regional) and the Mental Health Boards (many are regional), previously established with the likelihood of various confusing delivery systems.
 2. Removes the 425,000 population threshold authorizing a 25-member county Consolidated Human Services Board appointed by the county board of commissioners which shall serve as the policy-making, rule-making and administrative board of the consolidated human services agency with a Human Services Director appointed at the discretion of the county board of commissioners to report to the county manager or under the Human Services Agency with hiring and firing authority.
 3. Creates a 25-member Human Services Board which shall include: 8-members representing consumers, public advocates, 1-with a mental illness, 1-with a developmental disability, 1-person in recovery from substance abuse, 1-member representing families of a mentally ill person and 2-members representing consumers of other human services; 8-professional members, each with qualifications in one of these categories: 1-psychologist; 1-pharmacist, 1-engineer, 1-dentist, 1-optometrist, 1-veterinarian, 1-social worker, and 1-nurse; two physicians licensed to practice in NC, one of whom shall be a psychiatrist; one member of the board of commissioners; and, other members of the public representing various occupations. NOTE: N/A to most rural counties.
- The US Census Bureau depicts NC counties as 85 counties being rural and 15 counties as metropolitan.
- At the county board of commissioners discretion, the DSS and Health Departments' personnel can be removed from the NC State Personnel Act regardless of existing county personnel policies. NC counties already have the legal option to seek "substantially equivalent" status in their respective counties which would include their DSS and Health Department personnel. Currently, those under the State Personnel Act protects the state and counties by way of ensuring high standards in the administration of federal and state programs and greatly reduce and protects the state and counties from lawsuits.
- NC DSS and Health Department Directors are "Agents of the State," in the legal administration of federal and state human services programs funded predominantly by federal (about 72%), state (about 25%) and counties (about 3%); and, almost all county agencies administer basic and required federal and state statutory human services programs and no more – if counties elect to provide optional programs they fund it and create the rules – adopting S 433/H 580 will increase state liability and equate to a clear abdication of responsibility, oversight and administration of the very programs the NC General Assembly approves.
- NC Counties already have "control" over their DSS/Health Dept through budget approvals, facilities, staffing, personnel benefits, capital outlay projects, salaries; and, through representative appointments to the existing DSS/Health Dept. Boards.

RECOMMENDATION: Recommend that S 433 and H 580 be defeated and the existing provisions be upheld.

Summary

**Regarding S433: VOTE NO To
Consolidation of Administrative Functions of County Departments of
Social Services, Health Departments and Area Mental Health**

Harmful Real-life Examples

S433 Increases Likelihood of Political Cronyism and Unethical Practices in Local Government

- County Manager's wife applied for key management position at DSS and was not hired by the DSS Director because she was not the most qualified candidate; Manager would not speak to the DSS Director for 5 months – what would have occurred if the Director was directly supervised by the Manager as allowed under S433?
- County Commissioner applies for Medicaid for his aunt. Commissioner's aunt not eligible under program policy and guidelines. County Commissioner makes statement to the DSS Director "if I had the authority I would have you fired – my aunt needs help more than most of the people who come in here!" What would have occurred had the Commissioner had that authority provided under S433?
- DSS receives a fraud report on the cousin of a County Commissioner. Agency policy is to take all intentional fraud cases to court over a certain amount. Commissioner calls DSS Director and demands the case be dropped. DSS refuses and the case is taken to court. What happens if the Commissioner has the authority to have the DSS Director fired as provided in S433?
- County DSS receives a child abuse report on the County Commissioner's granddaughter whose parents are the Commissioner's daughter and a prominent member of the Sheriff's Department. The Commissioner calls the DSS Director and states "this is an erroneous referral and I demand to know who made it! I expect this investigation to be dropped immediately!" The Director proceeded on with the report and an investigation was conducted by another county. However, the home county eventually had to provide CPS intervention services once the case was substantiated. What would have happened had the Commissioner had the authority to fire the Director in this situation as allowed under S433?

Recommendation

Maintain Integrity in Governance of Local DSS

- The current Board of Social Services governance model as authorized through NCGS 108A must remain to assure apolitical governance rather than politically controlled governance.

Remember Mental Health Reform?

Let's not make that mistake again!

Potentially 98 times over!

NC County Department of Social Services Overview – S433

PURPOSE: This paper responds to S433 which will impede the equitable administration of services to NC citizens for federal and State DSS programs:

- The NC Social Services System established by the NC General Assembly has existed successfully for decades in providing a multitude of services to our needy citizens, **void of political influence** to ensure applicable federal and State laws are adhered to.
- Funding for DSS services, on average, come from 69% federal, 26% state and **5% county funds**.
- DSS Program requirements, rules and guidelines are established by the federal and State government which provide the funding with little to no discretion by the county DSS.
- **DSS probably is the most audited, inspected, surveyed and consulted department** in the county and perhaps in State government.
- The NC General Assembly details responsibilities for the investigation of child abuse, neglect and dependency to the county DSS in concert with and under the direct supervision of the court system.
- The NC General Assembly details responsibilities for the investigation of adult abuse, neglect and exploitation to the county DSS in coordination with and under the court system.
- **Almost all county DSS' programs are 100% based in law with no optional programs by the county** and if the county does operate and pay for any additional human services program(s) the county has exclusive control over the operation and expenditure of those county funds (**local flexibility already exists to the extent possible under federal law**).
- **The federal government requires personnel laws to be in place with administrators of federal programs** facilitated by the State Personnel Act and few NC counties are considered "substantially equivalent" in that regard.
- **Political patronage, influence and conflict of interest has no place in a county DSS** in the performance of our mission to adhere to and administer federal and State DSS programs.
- NC counties already have a relationship with their respective DSS and influence upon each, as many issues have to be approved by the local Board of Commissioners, the Board of Commissioners has two representatives on a five-member DSS Board and a fifth-member is appointed by the DSS Board for a majority vote for local influence, with the State Social Services Commission having two representatives and those recommendations for appointment come from the applicable county.
- **The DSS Board**, with hiring and firing authority over the DSS Director and influence in affecting DSS programs based in law acts as a **non-political entity** – this delicate non-political relationship **ensures fair and honest administration** of all programs and ensures staffing based on a uniform set of State standards.
- Large counties have the resources and means to facilitate a combined Human Services Board, other counties often do not.
- Placing the county manager in the direct supervisory role of DSS and requiring manager approval for hiring DSS employees dilutes and impedes the means to provide uniform and non-political program services to citizens.
- **S433 does not accomplish one benefit for our citizens for whom we serve; and, in all likelihood, adoption of the bill will complicate and exacerbate an already successful delivery system.**

CONCLUSION: S433 is not in the best interests of the needy citizens of North Carolina and we request its defeat.

PAGES ATTENDING

Senate
COMMITTEE: Health Care ROOM: 544

DATE: 4-6 TIME: 11 AM

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
¹ Lydia Stonehouse	Clemmons	Brunstetter
² Emily Jones	Mocksville	Brock
³ Bre'anna Smith	Wendell	Berger
⁴ ~~Michelle Horton~~	~~Flat Rock~~	~~W. McRedith~~
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Do not add names below the grid.

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HEALTH CARE COMMITTEE

APRIL 6, 2011

Name of Committee

Date

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Debra DeSantis	Jeffers, Mann & Artman Pediatrics
Julie Seibert	DMH/DD/SAS, DHHS
Jamie Hinton	NCCOB
Jennifer Epperson	NC DOJ
Jul Bon	Bon & Assoc
Hannah Silver	AFC
Tom V. Taylor	AFC
Melissa T. Cook	NCAAC
Joanne Stevens	Stevens lobby & nursing
Tennis Streets	NC DATS
Mary Beth	AARP-NC

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538 SCOTTS CR RD Sylva NC 28779
Jackson Co Health dept

DON Yousey

BRUNSWICK CO. Health Dept-
Bolivia, NC 28451

David Stank

Brunswick Co. Health Dept
Bolivia, NC 28422

DAVID Kolbrach

NC Board of Nursing

Martha Brock

Examiner.com

Kathy Baker

Southeastern Regional LME

JESSE GOODMAN

DAHS/DHSR

Sam Stewart

DAHS

DEL HUNTER

NCAFP

Don Horne

NCNA

[Signature]

Public Co Health

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APRIL 6, 2011

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William J Smith	Robeson H.D.
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Penny Liveberry	ITS
RAMON RODRIGO	WAKE COUNTY Human Services
Joe Brown	WAKE COUNTY
Sally Cameron	NC Psychological Assoc
Julie Hochsztein	NCOST
Ghnette Tolson	NCALHD
Mik Artman	Jeffers, Mann, & Artman Peds
Peggy Williams	Jeffers, Mann & Artman Peds

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Carl Dean	OSP
Thomas Moore	A MAN FOR ALL SEASONS
DANIEL BACH	TROUTMAN SANDERS
Amy McConkey	NC Deverage Assn
Maureen Goff	Smith Anderson
TRACY COLVARD	AAAE
Jeff Horton	DHHS - NHTSA
Bradley Mills	NCVMA
Roni Z. Le	NCCRA
Amy Whitel	NUMS

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FIRM OR AGENCY AND ADDRESS

Michelle Frarier

MF + S

Rosemarie Wenzel

108 St Andrews PL CH NC

Cheri Hardman

228 Gateway Dr CH NC

Butch Gunnells

WCTBA

[Signature]

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Michelle Brooks	UHS
BILL COX	DSI
John Murrell	CSC
Chip Murrell	Retired DSS Director
Sarah Preston	ACLU-NC
Susan Osborne	Alamance Co DSS Director
Angel Sams	NSS
Kay Paksoy	NASW-NC
DAVID BARNES	Pogonson
JEFF Woodard	Warren Co. DSS - Director
BJ Miller	Moses Cone
Martha McNeill	UHS

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APRIL 6, 2011

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TARA FIELDS

Boorchmarks

Ken M

11

Jim Holland

Buncombe County Human Svcs

Dean Plunkett

PS.

DAVID BARNES

PS.

Aly Miller

KLG

Melanie Rosh

NCCPPR

Jerry Parks

Albemarle Regional Health

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Cara W. Wood

Duke Pediatrics

Krystal Trizany

Duke Pediatrics

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Lois An Harris	LATA
Angie Harris	WM
Gunn King	NCACC
Jones Sue Bratton	NCMS
Ken Melton	K.M.A.
EARL MARETT	Johnston Co. DSS
Yvonne Copeland	nccep

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4-6-11

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Don Phil	TH/12
Paul Johnson	Tuborn
Dontae Catson	DSS
Pat Cameron	DSS.
Sharon Scott	DSS
Glenn Osborne	DSS
Dr. Al Wentzy	DSS
James P. Cessie	(Retired)
JAN PUESCH	EPW
Larry Presnell	NC Retiree School Personnel

25

SENATE HEALTH CARE COMMITTEE

April 13, 2011

MINUTES

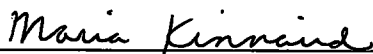
The Senate Health Care Committee met on Wednesday, April 13, 2011 in Room 544 of the Legislative Office Building. Sixteen members were in attendance along with staff Shawn Parker, Theresa Matula, Amy Jo Johnson, and Susan Barham.

Senator Bingham called the meeting to order at 11:04am and introduced the Sergeant-at-Arms and the Pages. Senator Kinnaird made a motion to consider the Proposed Committee Substitute for Senate Bill 307, AN ACT TO ESTABLISH THE NORTH CAROLINA SMART CARD PILOT PROGRAM TO UTILIZE BIOMETRICS TO COMBAT FRAUD (attached). The motion was granted and the bill was sponsored and explained by Senator Hartsell. Speaking on the bill from the audience was Anna Frenezian, a Program Manager for Identity & Privacy Assurance from the CSC. She is a certified smartcard expert. After discussion, a motion was made by Senator Clary for a favorable report. The motion carried and the report was favorable as to the bill.

The next bill considered was Senate Bill 437. Senator Kinnaird made a motion to consider the Proposed Committee Substitute for SB437, AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM (attached). The motion was granted and the bill was sponsored and explained by Senator Hartsell. Senator Mansfield submitted an amendment (attached) to the PCS for consideration. Senator Atwater made a motion to approve the amendment and the motion passed. Robin Huffman of the North Carolina Psychiatric Association was recognized from the audience to speak on the bill. After discussion Senator Pate made a motion to for a favorable report. The motion carried and the report was made as unfavorable as to bill, but favorable as to committee substitute bill.

The meeting was adjourned at 11:55am.

Respectfully submitted,


Maria Kinnaird, Committee Assistant


Senator Stan Bingham, Presiding Chair

Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

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 13, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 307	Smart Card Biometrics Against Medicaid Fraud.	Senator Hartsell
SB 437	Enact First Evaluation Program.	Senator Hartsell
SB 449	Task Force on Fraud Against Older Adults.	Senator Bingham
SB 450	Direct Care Worker Wage and Benefit Study.	Senator Bingham
SB 451	Extend Reporting on Baby Boomer Preparations.	Senator Bingham

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee
Wednesday, April 13, 2011, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 307	Smart Card Biometrics Against Medicaid Fraud.	Senator Hartsell
SB 437	Enact First Evaluation Program.	Senator Hartsell
SB 449	Task Force on Fraud Against Older Adults.	Senator Bingham
SB 450	Direct Care Worker Wage and Benefit Study.	Senator Bingham
SB 451	Extend Reporting on Baby Boomer Preparations.	Senator Bingham

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Thursday, April 14, 2011

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

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

S.B. **307** Smart Card Biometrics Against Medicaid Fraud.

Draft Number: 15136

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No .

S.B. **437** Enact First Evaluation Program.

Draft Number: 95060

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 307*
PROPOSED COMMITTEE SUBSTITUTE S307-CSSQ-9 [v.1]

4/11/2011 3:05:25 PM

Short Title: Smart Card Biometrics Against Medicaid Fraud.

(Public)

Sponsors:

Referred to:

March 10, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ESTABLISH THE NORTH CAROLINA SMART CARD PILOT PROGRAM
3 TO UTILIZE BIOMETRICS TO COMBAT FRAUD.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. Smart Card Pilot Program. – There is established under the
6 Department of Health and Human Services the North Carolina Smart Card Pilot Program. The
7 pilot program shall be administered by the Program Integrity Unit of the Division of Medical
8 Assistance. The Department shall determine the scope of the pilot program and may enter into
9 an agreement with a third-party vendor for the purpose of developing and executing the pilot
10 program in accordance with this act. The pilot program shall be initiated for a 12-month period.
11 The pilot program shall involve enrollment, distribution, and use of smart cards by all
12 recipients as replacements for currently used Medicaid assistance cards.

13 SECTION 2.(a) The pilot program shall be designed to do all of the following:

- 14 (1) Authenticate recipients at the onset and completion of each point of
15 transaction in order to prevent card sharing and other forms of fraud.
16 (2) Deny ineligible persons at the point of transaction.
17 (3) Authenticate providers at the point of transaction to prevent phantom billing
18 and other forms of provider fraud.
19 (4) Secure and protect the personal identity and information of recipients.
20 (5) Reduce the total amount of medical assistance expenditures by reducing the
21 average cost per recipient.

22 SECTION 2.(b) The pilot program may include all of the following:

- 23 (1) An information system for recording and reporting authenticated
24 transactions.
25 (2) An information system that interfaces with the appropriate State databases to
26 determine eligibility of recipients.
27 (3) A system that gathers analytical information to be provided to data-mining
28 companies in order to assist in data-mining processes.
29 (4) A smart card with the ability to store multiple recipients' information on one
30 card.
31 (5) No requirement for preenrollment of recipients.
32 (6) An image of the recipient stored on both the smart card and database.

33 SECTION 2.(c) In implementing the pilot program, the Department may do the
34 following:



* S 3 0 7 - C S S Q - 9 - V - 1 *

- (1) Have alternative methods of authentication of recipients.
- (2) Enter and store billing codes, deductible amounts, and bill confirmations.
- (3) Allow electronic prescribing services and prescription database integration and tracking in order to prevent medical error through information sharing and to reduce pharmaceutical abuse and lower health care costs.
- (4) Implement quick-pay incentives for providers when electronic prescribing services, electronic health records, electronic patient records, or computerized patient records used by providers automatically synchronize with recipients' smart cards and electronically submit a claim.
- (5) Allow the program, including, but not limited to, smart cards, fingerprint scanners, and card readers, to be adapted for use by other State programs administered by the Department and the Department of Human Services in order to reduce costs associated with the necessity of multiple cards per recipient.

SECTION 2.(d) The pilot program shall be considered a success if it meets the minimum criteria defined by this act and reduces the average monthly cost of recipients within the pilot program area by a minimum of three percent (3%). In the event that the pilot program does not meet the minimum criteria to be considered a success, the Department may extend and revise the pilot program as necessary and reevaluate the results. In order to evaluate the average monthly cost of recipients within the pilot program and develop the strategy necessary to target the highest rate of savings to the State plan, four sample sets of figures shall be analyzed for the pilot program, including the following:

- (1) Establishment of base figures. – Gather claims data for a first sample set, which shall include all claims for the recipients within the pilot program area and the average cost per recipient by provider type and county from at least the prior year for the exact time period for all areas in the pilot program.
- (2) Adjusted base figures for increase or decrease in cost of services. – In order to evaluate increases or decreases in the cost of services, a second sample set shall be gathered and adjusted to the base figures of the first sample set. The second sample set of claims data shall represent a rural area and an urban area not participating in the pilot program, with as close as possible demographics as the population of recipients in the pilot program areas, including specific data relating to sex, age, race, and ethnicity, county similarities, number of providers, and the average cost per recipient. This sample set shall be analyzed against the prior year's figures and compared to current year figures for the same time frame and area to determine an increase or decrease in cost of services. This sample shall not have any major changes from the prior year to the current year that would change the comparison, such as the introduction of managed care in the area. The increase or decrease in cost per recipient from this sampling shall be factored into the data set determined pursuant to subdivision (1) of this subsection to derive at an adjusted base figure or average cost per recipient per month.
- (3) Comparison of base figures to current figures. – A third sample set of data shall be gathered reflecting the claims data of the recipients and the average cost per recipient on a monthly basis during the pilot program by provider type. A comparison of the adjusted base figures arrived at by the prior sampling with the actual figures from this third sample set shall be made to determine how much the State saved by provider type. Recipients leaving the pilot program area to avoid fraud detection will be noted, thus the third sample set will be adjusted by claims derived outside of the pilot program area.

- 1 (4) Recipient surveying. – A fourth sample set of data shall be obtained by
2 sampling two percent (2%) of Medicaid recipients in the pilot program area
3 and shall be surveyed prior to the start of the pilot program to acknowledge
4 services used, frequency of services used, and satisfaction of services used.
5 This survey shall be taken again at the completion of the pilot program to
6 rate the level of satisfaction of the pilot program.

7 **SECTION 2.(e)** The pilot program shall not be expanded unless the General
8 Assembly provides for its continuation or expansion. During the pilot program, the Department
9 may consider the feasibility of expanding the pilot program, including the need to develop rules
10 and policies related to the following:

- 11 (1) The handling of lost, forgotten, or stolen cards.
12 (2) Enrolling all recipients, regardless of age, for participation in the program.
13 (3) Distributing and activating smart cards for all recipients.

14 **SECTION 3. Reports.** – By June 30, 2012, the Department shall submit a detailed
15 written report on the implementation and success of the smart card pilot program to the
16 Governor, to the Speaker of the House of Representatives, to the President Pro Tempore of the
17 Senate, to the Chairs of the Senate and House of Representatives Appropriations Committees,
18 and to the Fiscal Research Division.

19 **SECTION 4. Compliance and Prosecutions.** – This act shall be construed
20 consistent with the federal Social Security Act, and any provision of this article found to be in
21 conflict with the federal Social Security Act shall be deemed to be void and of no effect. If,
22 before implementing any provision of this act, the Department determines that a waiver or
23 authorization from a federal agency is necessary for implementation of that provision, the
24 Department shall request the waiver or authorization as soon as practicable. If, in connection
25 with the pilot program, the Department has reason to believe medical assistance fraud has been
26 committed, the Department shall refer such matters to the Attorney General or to the local
27 district attorney for prosecution, as appropriate.

28 **SECTION 5. Funds appropriated to the Department of Health and Human Services**
29 **for the 2010-2011 fiscal year for the purpose of fraud prevention shall not revert at the end of**
30 **the fiscal year and shall be carried forward to the 2011-2012 fiscal year to carry out the**
31 **purposes of this act.**

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



SENATE BILL 307: Smart Card Biometrics Against Medicaid Fraud

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S307-CSSQ-9

Date: April 12, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate Bill 307 will establish the North Carolina Smart Card Pilot Program to evaluate the use of a Smart Card containing biometrics as a replacement for current Medicaid assistance cards.*

[As introduced, this bill was identical to H337, as introduced by Reps. Tolson, Johnson, which is currently in House Health and Human Services, if favorable, Appropriations.]

CURRENT LAW: At this time, when an individual is approved for Medicaid, they receive a Medicaid identification card. This card contains the individual's name, address, date of birth, and their Medicaid identification number. It must be presented at the time of service to a Medicaid provider to verify eligibility.

BILL ANALYSIS: The PCS to Senate Bill 307 would establish the North Carolina Smart Card Pilot Program to replace the current Medicaid assistance cards with Smart Cards. Smart Cards are able to store a variety of digital information on a card the size of a typical credit card. The Pilot Program is designed to do the following:

- Authenticate recipients at the onset and completion of each point of transaction
- Deny ineligible persons at the point of transaction
- Authenticate providers at the point of transaction
- Secure and protect the personal identity and information of recipients
- Reduce the total amount of medical assistance expenditures by reducing average cost per recipient

This Pilot Program will last for 12 months. The bill allows for the Department of Health and Human Services (DHHS) to contract with a third-party vendor to execute the program.

The Pilot Program will not be extended unless the General Assembly provides for its continuation or expansion. The bill instructs DHHS to submit a report regarding the implementation and success of the program by June 30, 2012. The pilot program shall be considered a success if it meets the minimum criteria defined by this act and reduces the average monthly cost of recipients within the pilot program area by a minimum of three percent (3%).

The bill shall be construed as consistent with the federal Social Security Act and any provision found in conflict will be void. If DHHS determines that a waiver or authorization from a federal agency is necessary to carry out the program, DHHS will request the waiver or authorization. If DHHS has reason to believe that medical assistance fraud has been committed, those matters will be referred to the Attorney General.

The bill provides that funds appropriated to DHHS for the 2010-2011 fiscal year for the purposes of fraud prevention will not revert at the end of the fiscal year and will be carried forward to the 2011-2012 fiscal year to carry out the provision in this act.

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

S307-SMTK-13(CSSQ-9) v2

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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SENATE BILL 307*

Short Title:	Smart Card Biometrics Against Medicaid Fraud.	(Public)
Sponsors:	Senators Hartsell; and Mansfield.	
Referred to:	Health Care.	

March 10, 2011

A BILL TO BE ENTITLED
AN ACT TO ESTABLISH THE NORTH CAROLINA SMART CARD PILOT PROGRAM
TO UTILIZE BIOMETRICS TO COMBAT FRAUD.

The General Assembly of North Carolina enacts:

SECTION 1. Definitions. – The following definitions apply in this act:

- (1) **Claim.** – Any request or demand, whether under a contract or otherwise, for money, property, or services, that is made to the North Carolina Medicaid program, or to any officer, employee, fiscal intermediary, grantee, or contractor of the North Carolina Medicaid program, if the North Carolina Medicaid program provides or will provide any portion of the money or property requested or demanded, or if the North Carolina Medicaid program will reimburse the contractor, grantee, or other recipient for any portion of the money or property requested or demanded. A claim includes a request or demand made orally, in writing, electronically, or magnetically and meets all of the following requirements:
 - a. Identifies a product or service provided or purported to have been provided within the State of North Carolina to a recipient as reimbursable under the medical assistance program, without regard to whether the money that is requested or demanded is paid.
 - b. States the income earned or expense incurred by a provider in providing a product or a service and that is used to determine a rate of payment under the medical assistance program.
 - c. Has been generated at the point of transaction and as a result of recipients participating in either biometric or alternative method authentication as defined in this Article.
- (2) **Medical assistance card.** – Medicaid cards currently used by recipients prior to the implementation of the statewide rollout pursuant to this Article, and which will be replaced by smart cards pursuant to this Article, which shall identify eligible recipients and their account numbers and shall be used by recipients to obtain medical assistance for which payment by the State shall be tendered.
- (3) **Multifactor authentication.** – A security process in which a user provides multiple means of identification, one of which is a token, such as a smart card, and the other of which is representative of who the user is, such as a fingerprint and photo.



- (4) Point of transaction. – The act of a recipient obtaining a service, product, or both provided by a provider, which service, product, or both is submitted as a claim to be paid for by the State Medicaid program.

SECTION 2.(a) Smart Card Pilot Program. – There is established under the Department of Health and Human Services the North Carolina Smart Card Pilot Program. The pilot program shall be administered by the Program Integrity Unit of the Division of Medical Assistance. The Department shall determine the scope of the pilot program and may enter into an agreement with a third-party vendor for the purpose of developing and executing the pilot program in accordance with this act. The pilot program shall be initiated for a 12-month period. The pilot program shall involve enrollment, distribution, and use of smart cards by all recipients as replacements for currently used Medicaid assistance cards. The pilot program shall involve the distribution of fingerprint scanners and card readers at each provider location within the designated counties.

SECTION 2.(b) The pilot program shall be designed to do all of the following:

- (1) Authenticate recipients at the onset and completion of each point of transaction in order to prevent card sharing and other forms of fraud.
- (2) Deny ineligible persons at the point of transaction.
- (3) Authenticate providers at the point of transaction to prevent phantom billing and other forms of provider fraud.
- (4) Secure and protect the personal identity and information of recipients.
- (5) Reduce the total amount of medical assistance expenditures by reducing the average cost per recipient.

SECTION 2.(c) The pilot program shall include all of the following:

- (1) Smart cards for storage of recipients' State benefit information, insurance information, and other general health information for the purpose of replacing existing medical assistance cards. The smart cards shall include recipients' prescription history information in order to assist in prevention of drug overutilization and to mitigate costs and risks associated with prescription drugs. Sensitive information to be stored shall be split into multiple parts and encrypted, with one part being stored on the host database.
- (2) Biometric fingerprint scanners and card readers for the purpose of real-time, multifactor authentication or recipients' fingerprint templates and smart cards. Biometric fingerprint scanners and card readers shall reside at the point of transaction with providers.
- (3) Biometric fingerprint readers for authentication by providers.
- (4) A secure finger-imaging system that is compliant with the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191. The finger-imaging system shall store a fingerprint template on a central host system for authentication purposes, rather than on the smart card, to allow authentication in the event of lost, stolen, or forgotten cards and to prevent Medicaid fraud associated with card reproduction and card sharing. The system shall take a fingerprint image and convert it into a binary PIN number, known as a fingerprint template, and store the template, rather than the fingerprint image, on the central host system. The fingerprint template shall not be able to be recreated into an actual fingerprint image.
- (5) An information system for recording and reporting authenticated transactions.
- (6) An information system that interfaces with the appropriate State databases to determine eligibility of recipients.

- (7) A system that gathers analytical information to be provided to data-mining companies in order to assist in data-mining processes.
- (8) A smart card with the ability to store multiple recipients' information on one card.
- (9) No requirement for preenrollment of recipients.
- (10) An image of the recipient stored on both the smart card and database.

SECTION 2.(d) In implementing the pilot program, the Department may do the following:

- (1) Have an alternative method of authentication of recipients when biometric fingerprint images cannot be used and to address specific mandates needed to obtain a waiver or authorization from the federal Centers for Medicare and Medicaid Services.
- (2) Enter and store billing codes, deductible amounts, and bill confirmations.
- (3) Allow electronic prescribing services and prescription database integration and tracking in order to prevent medical error through information sharing and to reduce pharmaceutical abuse and lower health care costs.
- (4) Implement quick-pay incentives for providers when electronic prescribing services, electronic health records, electronic patient records, or computerized patient records used by providers automatically synchronize with recipients' smart cards and electronically submit a claim.
- (5) Allow the program, including, but not limited to, smart cards, fingerprint scanners, and card readers, to be adapted for use by other State programs administered by the Department and the Department of Human Services in order to reduce costs associated with the necessity of multiple cards per recipient.

SECTION 2.(e) The pilot program shall be considered a success if it meets the minimum criteria defined by this act and reduces the average monthly cost of recipients within the pilot program area by a minimum of three percent (3%). In the event that the pilot program does not meet the minimum criteria to be considered a success, the Department may extend and revise the pilot program as necessary and reevaluate the results. In order to evaluate the average monthly cost of recipients within the pilot program and develop the strategy necessary to target the highest rate of savings to the State plan, four sample sets of figures shall be analyzed for the pilot program, including the following:

- (1) Establishment of base figures. – Gather claims data for a first sample set, which shall include all claims for the recipients within the pilot program area and the average cost per recipient by provider type and county from at least the prior year for the exact time period for all areas in the pilot program.
- (2) Adjusted base figures for increase or decrease in cost of services. – In order to evaluate increases or decreases in the cost of services, a second sample set shall be gathered and adjusted to the base figures of the first sample set. The second sample set of claims data shall represent a rural area and an urban area not participating in the pilot program, with as close as possible demographics as the population of recipients in the pilot program areas, including specific data relating to sex, age, race, and ethnicity, county similarities, number of providers, and the average cost per recipient. This sample set shall be analyzed against the prior year's figures and compared to current year figures for the same time frame and area to determine an increase or decrease in cost of services. This sample shall not have any major changes from the prior year to the current year that would change the comparison, such as the introduction of managed care in the area. The increase or decrease in cost per recipient from this sampling shall be factored

into the data set determined pursuant to subdivision (1) of this subsection to derive at an adjusted base figure or average cost per recipient per month.

(3) Comparison of base figures to current figures. – A third sample set of data shall be gathered reflecting the claims data of the recipients and the average cost per recipient on a monthly basis during the pilot program by provider type. A comparison of the adjusted base figures arrived at by the prior sampling with the actual figures from this third sample set shall be made to determine how much the State saved by provider type. Recipients leaving the pilot program area to avoid fraud detection will be noted, thus the third sample set will be adjusted by claims derived outside of the pilot program area.

(4) Recipient surveying. – A fourth sample set of data shall be obtained by sampling two percent (2%) of Medicaid recipients in the pilot program area and shall be surveyed prior to the start of the pilot program to acknowledge services used, frequency of services used, and satisfaction of services used. This survey shall be taken again at the completion of the pilot program to rate the level of satisfaction of the pilot program.

SECTION 2.(f) The pilot program shall not be expanded unless the General Assembly provides for its continuation or expansion. During the pilot program, the Department may consider the feasibility of expanding the pilot program, including the need to develop rules and policies related to the following:

- (1) The handling of lost, forgotten, or stolen cards or situations in which a fingerprint match cannot be confirmed.
- (2) Enrolling all recipients, regardless of age, for participation in the program.
- (3) Distributing and activating smart cards for all recipients.
- (4) Distributing and installing fingerprint scanners and card readers within provider locations. The procedures shall include shipping the equipment to providers and providing simple step-by-step instructions for installation of the equipment.

SECTION 3. Reports. – By June 30, 2012, the Department shall submit a detailed written report on the implementation and success of the smart card pilot program to the Governor, to the Speaker of the House of Representatives, to the President Pro Tempore of the Senate, to the Chairs of the Senate and House of Representatives Appropriations Committees, and to the Fiscal Research Division.

SECTION 4. Compliance and Prosecutions. – This act shall be construed consistent with the federal Social Security Act, and any provision of this article found to be in conflict with the federal Social Security Act shall be deemed to be void and of no effect. If, before implementing any provision of this act, the Department determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the Department shall request the waiver or authorization as soon as practicable. If, in connection with the pilot program, the Department has reason to believe medical assistance fraud has been committed, the Department shall refer such matters to the Attorney General or to the local district attorney for prosecution, as appropriate.

SECTION 5. Funds appropriated to the Department of Health and Human Services for the 2010-2011 fiscal year for the purpose of fraud prevention shall not revert at the end of the fiscal year and shall be carried forward to the 2011-2012 fiscal year to carry out the purposes of this act.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 437*
PROPOSED COMMITTEE SUBSTITUTE S437-CSSQ-10 [v.1]

4/12/2011 4:50:43 PM

Short Title: Enact First Evaluation Program.

(Public)

Sponsors:

Referred to:

March 29, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO
3 ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL
4 (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF
5 INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE
6 FIRST EVALUATION PILOT PROGRAM.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is
9 amended by adding a new section to read:

10 "§ 122C-263A. Secretary's authority to waive requirement of first examination by
11 physician or eligible psychologist; training of certified providers performing
12 first examinations.

13 (a) The Secretary of Health and Human Services may, upon request of an LME, waive
14 the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through
15 G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible
16 psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as
17 applicable, as follows:

18 (1) The Secretary has received a request from an LME to substitute for a
19 physician or eligible psychologist, a licensed clinical social worker, a
20 master's level psychiatric nurse, a licensed professional counselor, or a
21 master's level certified clinical addictions specialist who is also licensed in
22 accordance with Article 18A of Chapter 90 of the General Statutes to
23 conduct the initial (first-level) examinations of individuals meeting the
24 criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of
25 request, the LME shall specifically describe all of the following:

26 a. How the purpose of the statutory requirement would be better served
27 by waiving the requirement and substituting the proposed change
28 under the waiver.

29 b. How the waiver will enable the LME to improve the delivery or
30 management of mental health, developmental disabilities, and
31 substance abuse services.

32 c. How the health, safety, and welfare of individuals will continue to be
33 at least as well protected under the waiver as under the statutory
34 requirement.



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- 1 (2) The Secretary shall review the request and may approve it upon finding all
2 of the following:
3 a. The request meets the requirements of this section.
4 b. The request furthers the purposes of State policy under G.S. 122C-2
5 and mental health, developmental disabilities, and substance abuse
6 services reform.
7 c. The request improves the delivery of mental health, developmental
8 disabilities, and substance abuse services in the counties affected by
9 the waiver and also protects the health, safety, and welfare of
10 individuals receiving these services.
11 (3) The Secretary shall evaluate the effectiveness, quality, and efficiency of
12 mental health, developmental disabilities, and substance abuse services and
13 protection of health, safety, and welfare under the waiver.
14 (4) A waiver granted by the Secretary under this section shall be in effect for a
15 period of three years.
16 (5) In no event shall the substitution of a licensed clinical social worker,
17 master's level psychiatric nurse, a licensed professional counselor, or
18 master's level certified clinical addictions specialist under a waiver granted
19 under this section be construed as authorization to expand the scope of
20 practice of the licensed clinical social worker, the master's level psychiatric
21 nurse, the licensed professional counselor or the master's level certified
22 clinical addictions specialist.
23 (6) The Department shall assure that staff performing the duties have
24 successfully completed the Department's standardized training program and
25 examination and are properly trained and privileged to perform the functions
26 identified in the waiver.
27 (7) The LME shall assure that a physician is available at all times to provide
28 backup support to include telephone consultation and face-to-face
29 evaluation, if necessary.
30 (b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse
31 Services shall expand its standardized certification training program to include refresher
32 training for all certified providers performing first examinations pursuant to subsection (a) of
33 this section."

34 **SECTION 2.** This act becomes effective October 1, 2011.



SENATE BILL 437: Enact First Evaluation Program

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: First Edition

Date: April 4, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *Senate Bill 437 codifies a current pilot program which allowed certain trained Master's level professionals conduct the initial examination of a person as part of the involuntary commitment process.*

[As introduced, this bill was identical to H423, as introduced by Rep. Hurley, which is currently in House Health and Human Services.]

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 an 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 Session Law 2010-119 "First Evaluation Pilot Program" the Secretary is authorized to approve up to 20 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 The pilot program expires October 1, 2012.

BILL ANALYSIS:

Senate Bill 437 authorizes the Secretary of Health and Human Services 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. The bill sets the standards for which the Secretary will make his or her decision including requiring the LME to provide an adequate description on how, under the waiver, service delivery will improve while maintaining or improving the purpose and safeguards of the current statutory requirements.

The bill limits the substitution to licensed staff specifically trained to perform the evaluation and requires an LME to assure that a physician is available at all times to provide support, including telephone consultation and face to face evaluation. The bill directs the Division of MH/DD/SAS to expand its standardized training program to include refresher training and limits the waiver to a time period of three years.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

¹ G.S. 122C-261

² G.S. 122C-263(c)

³ SL 2003-178, as amended by SL 2006-66, SL 2007-504, SL 2009-304, and SL 2010-119

Senate Bill 437

Page 2

BACKGROUND: In 2003, the General Assembly passed legislation (S.L. 2003-178) which has been referred to as the "First Commitment Pilot Program". The legislation allowed the Secretary 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. Under the Pilot Program, the Secretary could grant waivers to up to five LMEs for periods of time not to exceed three years and required that participating LMEs, "...assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary."

The Appropriations Act of 2006 extended the pilot by 1 year. That Fall of 2006, the Department made a presentation and report on the pilot to the Legislative Oversight Committee on MH/DD/SAS (LOC) in which it recommended that it be made permanent and extended State wide. The General Assembly enacted SL 2007-504 which provided a three year extension and authorized up to five more LMEs. The Secretary was authorized in SL 2009-340 to expand the program to 15 LMEs and in SL 2010-113 to expand the program to 20 LMEs (there are currently 23 LMEs statewide).

S437-SMSQ-10(e1) v2



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 437*

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

S437-ASQ-34 [v.1]

Page 1 of 1

Comm. Sub. [YES]
Amends Title [NO]
First Edition

Date 4, 13, 2011

Senator Mansfield

1 moves to amend the Proposed Committee Substitute on page 1, lines 21-22, by rewriting the
2 lines to read:

3 "master's level certified clinical addictions specialist in accordance with subdivision (8) of this
4 section to";

5
6 And on page 2, lines 29-30, by inserting in between the lines the following:

7 "(8) A master's level certified clinical addiction specialist shall only be
8 authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-
9 281(a).".

10
11
SIGNED

Eric L. Mansfield

Amendment Sponsor

SIGNED

Stan Bingham

Committee Chair if Senate Committee Amendment

ADOPTED

X

FAILED

TABLED



* S 4 3 7 - A S Q - 3 4 - V - 1 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 437*

Short Title:	Enact First Evaluation Program.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Health Care.	

March 29, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-263A. Secretary's authority to waive requirement of first examination by physician or eligible psychologist; training of certified providers performing first examinations.

(a) The Secretary of Health and Human Services may, upon request of an LME, waive 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 master's level psychiatric nurse, or a master's 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). In making this type of request, the LME shall specifically describe all of the following:

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 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 all of the following:

a. The request meets the requirements of this section.



- 1 b. The request furthers the purposes of State policy under G.S. 122C-2
2 and mental health, developmental disabilities, and substance abuse
3 services reform.
4 c. The request improves the delivery of mental health, developmental
5 disabilities, and substance abuse services in the counties affected by
6 the waiver and also protects the health, safety, and welfare of
7 individuals receiving these services.
8 (3) The Secretary shall evaluate the effectiveness, quality, and efficiency of
9 mental health, developmental disabilities, and substance abuse services and
10 protection of health, safety, and welfare under the waiver.
11 (4) A waiver granted by the Secretary under this section shall be in effect for a
12 period of three years.
13 (5) In no event shall the substitution of a licensed clinical social worker,
14 master's level psychiatric nurse, or master's level certified clinical addictions
15 specialist under a waiver granted under this section be construed as
16 authorization to expand the scope of practice of the licensed clinical social
17 worker, the master's level psychiatric nurse, or the master's level certified
18 clinical addictions specialist.
19 (6) The Department shall assure that staff performing the duties are trained and
20 privileged to perform the functions identified in the waiver.
21 (7) The LME shall assure that a physician is available at all times to provide
22 backup support to include telephone consultation and face-to-face
23 evaluation, if necessary.
24 (b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse
25 Services shall expand its standardized certification training program to include refresher
26 training for all certified providers performing first examinations pursuant to subsection (a) of
27 this section."

28 **SECTION 2.** This act becomes effective October 1, 2011.

VISITOR REGISTRATION SHEET

Committee on Health Care
Name of Committee

4/13/11
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
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Shirley Perkins	Perkins Law Firm
Paul Enderson	Youth Villages
Abbie B Conner	Capitol Hill
J. Benuley	GLC
K. W. Hest	PERSON
Michelle Frazier	MFTS
BRUCE THOMPSON	PARKER POE
ZEB AILEY	N.M.R.S
Mr. Joseph DeLeon	
Royelle Seward	

VISITOR REGISTRATION SHEET

Committee on Health Care
Name of Committee

4/13/11
Date

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BJ Miller	Moses Cone
Angie Hauer	Williams Miller
Julie Hochstein	NC DST
Becki Gray	John Locke Foundation
Marlene Foster	PFizer
Joseph Peters	JP Assoc
Mary Bethe	ABRO-NC
Jonah Ziff	UNC opt. & lndg
Ian Buchanan	UNC Health Care
Annie Smith	Youth Villages

VISITOR REGISTRATION SHEET

Committee on Health Care

4/13/11

Name of Committee

Date

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Kevin O'Neal, MD	Western Wake Eye Center
Bill Profilis	NCMS
MATTHEW APPENZELLER	NCMS
Joanne Steven	NCNA SCNA
Susan Harrison	NCNA SCNA
Robin Huffman	NC Psychiatric Assoc
Jon Cur	Jordan
Chp Boon	NCMS
DAVID BARNES	PS
Christine Cuy	Wakenet
221 MYNARD	NCNFD

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Committee on Health Care

4/13/11

Name of Committee

Date

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Ivonne Copeland	NCCCP
Paul Yeager	Inform Inc
U. R. R.	CSS
Jeff H. Am	DHHS - DHR
Jesse Goodman	DHHS / DHR
Dave Halbrook	NC Board of Nursing
James Ryan	NCMS
Dan Berastem	NCMS
John Wright	NCMS
Theresa M.	Ellen W. Allen

VISITOR REGISTRATION SHEET

Committee on Health Care
Name of Committee

4/13/11
Date

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for Mr	Bank
Matt Wolfe	Poker Pie
Kevin Gertsch	NCMS
James Wrzosek	NCMS
Bill Hargis	Verizon
MARTY BROCK	AHIP
Cameron Graham	HWTF
Lynna Grubel	HWTF
Ramkalia	Nelson Muller
Mami W. Idy	Novant

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Committee on Health Care
Name of Committee

4/13/11
Date

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Mary Justice	Warren Co. Jr. Center
Vernice Perry	Warren Co. Jr. Center
Walter Palmer	Warren Co. Jr. Center
Margaret Palmer	Warren County
Nancy Williams	Warren County
Alvin Clayton	Warren County
(Marian Jones	Warren County
Edith Wright	Warren County
Eva M. Shaw	Warren County
Attie Moore	Warren County
Ed Clayton	

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Committee on Health Care

4/13/11

Name of Committee

Date

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CLERK

NAME

FIRM OR AGENCY AND ADDRESS

[Signature]

[Signature]

John Walker

CSC

BELL COX

DSI

John Minnich

CSC

Nicole Fisher

John Locke Foundation

RAN COBIE

NC Center for Public Policy Research

Emelyn Hawthorne

ETOR

Perry Buffie

School of Gov.

Tara L. Fields

Benchmarks

Tim Shaheen

Strategic Behavioral Health

Colleen Kachaneck

NCEP

VISITOR REGISTRATION SHEET

Committee on Health Care
Name of Committee

4/13/11
Date

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Fred Bonn	Bone Asso.
CO Donald	The Insider
Barbara Carlson	PRON
John Baerlich	AstraZeneca
Emily Grimm	MWC
Corye Dunn	DRNC
Annaliese Dolph	DRNC
Dennis Streets	NC-DAAS
Kay Paksoy	NASW-NC
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Committee on Health Care
Name of Committee

4/13/11
Date

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CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Jane Royster Tuck	Warren Co. Senior Center
Charles Jefferson	Warren County Senior Center
G. J. Whit	News 14
Mark Olexik	News 14

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, April 20, 2011

Room 544, LOB

The Senate Committee on Health Care met at 11:00 a.m. on Wednesday, April 20, 2011, in Room 544 of the Legislative Office Building. Eleven members were present with Senator Louis Pate presiding.

Senator Pate called the meeting to order, welcomed everyone and introduced the Sergeants-at-Arms: Chester White, Billy Fritscher and Bob Myrick. He then introduced the Pages assisting with the meeting: David Gravitt from King, sponsored by Senator East; Alex Loftin from Wilmington, sponsored by Senator Goolsby; Brittanie Kelly of Raleigh, sponsored by Senator Blue; Zachary Dale of Cary, sponsored by Senator Bingham; Robert Musselwhite of New Bern, sponsored by Senator Preston; Kristen Johnson of Cary, sponsored by Senator Blue; and Nathan Fisher of Charlotte, sponsored by Senator Rucho.

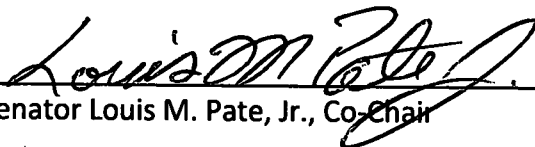
Senator Pate recognized Senator Bingham to explain the Committee Substitute for SB 449, "Task Force on Fraud Against Older Adults." After the explanation, Senator Robinson moved for a Favorable Report to the PCS with Unfavorable to the Original Bill. The motion carried.

SB 450, "Direct Care Worker Wage and Benefit Study" was explained with an amendment by Senator Bingham. Senator Atwater made a motion for a Favorable Report as Amended to be rolled into a PCS, Unfavorable to the Original Bill. The motion passed.

SB 451, "Extend Reporting on Baby Boomer Preparations," was next to be explained by Senator Bingham. Senator Blake made a motion that the bill receive a Favorable Report; the motion carried.

SB 307, "Smart Card Biometrics Against Medicaid Fraud," came before the Committee a second time as a PCS. Senator Hartsell explained the bill. Senator Bingham made a motion for a Favorable Report to the PCS, but Unfavorable to the Original Bill. Motion passed.

Having heard all bills on the agenda, Senator Pate adjourned the meeting at 11:25 a.m.


Senator Louis M. Pate, Jr., Co-Chair


Edna Pearce, Committee Assistant

Edna Pearce (Sen. Pate)

From: Maria Kinnaird (Sen. Bingham)
nt: Thursday, April 14, 2011 1:12 PM
To: Sen. Debbie Clary
Cc: Lynn Tennant (Sen. Clary)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wed, 04-20-2011 at 11:00 AM

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 20, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 449	Task Force on Fraud Against Older Adults.	Senator Bingham
SB 450	Direct Care Worker Wage and Benefit Study.	Senator Bingham
SB 451	Extend Reporting on Baby Boomer Preparations.	Senator Bingham
SB 512	Adult Day Care/Overnight Respite Program.	Senator Clary

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, April 20, 2011

Room 544 LOB

11:00 AM

Senator Louis Pate, Presiding

AGENDA

WELCOME AND OPENING REMARKS

BILLS TO BE CONSIDERED

SB 449	Task Force on Fraud Against older Adults
SB 450	Direct Care Worker Wage and Benefit Study
SB 451	Extend Reporting on Baby Boomer Preparations
SB 307	Smart Card Biometrics Against Medicaid Fraud

BILL SPONSORS

Senator Bingham
Senator Bingham
Senator Bingham
Senator Hartsell

OTHER BUSINESS

ADJOURNMENT

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Thursday, April 21, 2011

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

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

S.B.	450	Direct Care Worker Wage and Benefit Study.
		Draft Number: PCS 85185
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: No

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO
COMMITTEE SUBSTITUTE BILL NO. 2**

S.B.(CS #1) 307	Smart Card Biometrics Against Medicaid Fraud.
	Draft Number: PCS 85184
	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 Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, April 20, 2011

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

FAVORABLE

S.B.	451	Extend Reporting on Baby Boomer Preparations.
		Sequential Referral: None
		Recommended Referral: None

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

S.B.	449	Task Force on Fraud Against Older Adults.
		Draft Number: PCS55283
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2011

S

1

SENATE BILL 449*

Short Title: Task Force on Fraud Against Older Adults. (Public)

Sponsors: Senators Bingham; Allran, Atwater, Blake, Brunstetter, Forrester, Newton, Preston, Rabon, and Stevens.

Referred to: Health Care.

March 30, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE CONSUMER PROTECTION DIVISION, DEPARTMENT OF JUSTICE, TO COORDINATE A TASK FORCE ON FRAUD AGAINST OLDER ADULTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

Whereas, the Federal Trade Commission reports that North Carolina ranks 24th among the 50 states in the number of fraud complaints per capita and 21st in the number of identity theft complaints per capita; and

Whereas, the Federal Trade Commission reports that, for 2008, consumers over age 50 account for 26% of identity theft complaints and 30% of fraud complaints; and

Whereas, the March 2010 North Carolina Center for Public Policy Research publication on issues involving older adults contained a segment that highlighted issues involving fraud against older adults in North Carolina; Now, therefore, The General Assembly of North Carolina enacts:

SECTION 1.(a) The Consumer Protection Division, Department of Justice, shall coordinate a Task Force on Fraud Against Older Adults. The Task Force shall include representatives from the Consumer Protection Division, Department of Justice; Division of Aging and Adult Services, Department of Health and Human Services; North Carolina Senior Consumer Fraud Task Force; North Carolina Association of County Directors of Social Services; the Banking Commission; and other associations as approved by the Consumer Protection Division.

SECTION 1.(b) The Task Force shall include, but should not be limited to, examination of the following issues:

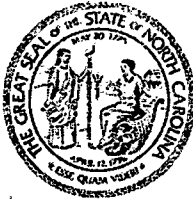
- (1) Identifying, clarifying, and strengthening laws to provide older adults a broader system of protection against abuse and fraud.
- (2) Establishing a statewide system to enable reporting on incidents of fraud and mistreatment of older adults.
- (3) Identifying opportunities for partnership among the Banking Commission, the financial management industry, and law enforcement agencies to prevent fraud against older adults.
- (4) Granting the Attorney General authority to initiate prosecutions for fraud against older adults.

SECTION 1.(c) The Task Force shall make an interim report to the North Carolina Study Commission on Aging on or before November 1, 2011, and a final report including findings, recommendations, and draft legislation on or before October 1, 2012.

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



* S 4 4 9 - V - 1 *



SENATE BILL 449: Task Force on Fraud Against Older Adults

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: First Edition

Date: April 5, 2011
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *Senate Bill 449 directs the Consumer Protection Division, Department of Justice, to coordinate a task force on fraud against older adults. This bill is a recommendation from the North Carolina Study Commission on Aging.*

[As introduced, this bill was identical to H110, as introduced by Reps. Farmer-Butterfield, Weiss, Pierce, Hurley, which is currently in House Health and Human Services.]

BILL ANALYSIS: Senate Bill 449 would require the Consumer Protection Division, Department of Justice to coordinate a Task Force on Fraud Against Older Adults to exam the following issues:

- (1) Identifying, clarifying, and strengthening laws to provide older adults a broader system of protection against abuse and fraud.
- (2) Establishing a statewide system to enable reporting on incidents of fraud and mistreatment of older adults.
- (3) Identifying opportunities for partnership among the Banking Commission, the financial management industry, and law enforcement agencies to prevent fraud against older adults.
- (4) Granting the Attorney General authority to initiate prosecutions for fraud against older adults.

Membership of the Task Force would include representatives from the following entities:

- Consumer Protection Division, DOJ
- Division of Aging and Adult Services, DHHS
- NC Senior Consumer Fraud Task Force
- NC Association of County Directors of Social Services
- Banking Commission
- Associations approved by Consumer Protection Division, DOJ

The Task Force is required to make an interim report to the Study Commission on Aging on or before November 1, 2011 and a final report on or before October 1, 2010.

EFFECTIVE DATE: Senate Bill 449 would become effective when it becomes law.

BACKGROUND: This bill is a recommendation from the NC Study Commission on Aging. The Commission's recommendation was based on research and recommendations by the NC Center for Public Policy Research and a January 13, 2011 presentation by Ran Coble, Director. The NC Center for Public Policy Research made four recommendations aimed at preventing and reducing fraud committed against older adults. In response, the Commission on Aging recommended a Task Force to research the issues and to report findings, recommendations, and draft legislation.

The Office of the Attorney General, North Carolina Division of Aging and Adult Services, DHHS, and AARP established a NC Senior Consumer Fraud Task Force in 1998. The goals of the Senior Consumer Fraud Task Force are broader than the task force created by SB 449. The Task Force created by SB 449 is intended to primarily address the issues identified in the bill. In order to keep all parties informed, a representative of the broader NC Senior Consumer Fraud Task Force has been included in the task force created by SB 449.

S449-SMSH-27(e1) v3

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

S

D

**SENATE BILL 450*
PROPOSED COMMITTEE SUBSTITUTE S450-PCS85185-SQ-14**

Short Title: Direct Care Worker Wage and Benefit Study.

(Public)

Sponsors:

Referred to:

March 30, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT A STUDY OF DIRECT CARE WORKER WAGES AND BENEFITS
TO EXAMINE WAYS TO REDUCE TURNOVER AND ADDRESS THE
ANTICIPATED DIRECT CARE WORKER SHORTAGE RESULTING FROM
INCREASED DEMAND FROM AGING BABY BOOMERS, 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 study of direct care worker wages and benefits and the impact these have on the supply of prospective employees and employee turnover. The study shall include representatives from the Division of Health Service Regulation, Division of Aging and Adult Services, and the Division of Medical Assistance, Department of Health and Human Services; the Labor Market Information Division, Employment Security Commission; 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; the North Carolina Assisted Living Association; the North Carolina Association of Long Term Care Facilities; the North Carolina Adult Day Services Association; and the North Carolina Association of Non-Profit Homes for the Aging.

SECTION 1.(b) Consistent with Recommendation 3 contained in the report on S.L. 2010-69, the study shall focus on wages and benefits paid to direct care workers and ways to increase the supply of direct care workers and to reduce turnover rates. The study shall examine, but is not limited to, the elements listed below.

- (1) Rates of pay and benefits currently offered by those entities that employ direct care workers.
- (2) Direct care worker turnover rates found in those entities that employ direct care workers.
- (3) Research indicating what factors increase retention of direct care workers.
- (4) Research indicating whether there is an optimal combination of salary and benefits that reduces direct care worker turnover and examples of where those levels have been effective at lowering turnover.
- (5) Research indicating whether merit pay results in improved job performance and reduces turnover of direct care workers.



- 1 (6) Possible changes to Medicaid and State/County Special Assistance that
2 could reward direct care workers of providers who achieve NC NOVA
3 special licensure status.
4 (7) Whether individuals receiving unemployment could be trained as direct care
5 workers.
6 (8) Ways the State could encourage an increase in the supply of direct care
7 workers.

8 **SECTION 1.(c)** The Division of Health Service Regulation shall report the results
9 of this study to the North Carolina Study Commission on Aging on or before October 1, 2012.

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2011

S

1

SENATE BILL 450*

Short Title: Direct Care Worker Wage and Benefit Study.

(Public)

Sponsors: Senators Bingham; Allran, Atwater, Blake, Brunstetter, Forrester, Preston, Rabon, and Stevens.

Referred to: Health Care.

March 30, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT A STUDY OF DIRECT CARE WORKER WAGES AND BENEFITS TO EXAMINE WAYS TO REDUCE TURNOVER AND ADDRESS THE ANTICIPATED DIRECT CARE WORKER SHORTAGE RESULTING FROM INCREASED DEMAND FROM AGING BABY BOOMERS, 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 study of direct care worker wages and benefits and the impact these have on the supply of prospective employees and employee turnover. The study shall include representatives from the Division of Health Service Regulation, Division of Aging and Adult Services, and the Division of Medical Assistance, Department of Health and Human Services; the Labor Market Information Division, Employment Security Commission; 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; the North Carolina Assisted Living Association; the North Carolina Association of Long Term Care Facilities; and the North Carolina Association of Non-Profit Homes for the Aging.

SECTION 1.(b) Consistent with Recommendation 3 contained in the report on S.L. 2010-69, the study shall focus on wages and benefits paid to direct care workers and ways to increase the supply of direct care workers and to reduce turnover rates. The study shall examine, but is not limited to, the elements listed below.

- (1) Rates of pay and benefits currently offered by those entities that employ direct care workers.
- (2) Direct care worker turnover rates found in those entities that employ direct care workers.
- (3) Research indicating what factors increase retention of direct care workers.
- (4) Research indicating whether there is an optimal combination of salary and benefits that reduces direct care worker turnover and examples of where those levels have been effective at lowering turnover.
- (5) Research indicating whether merit pay results in improved job performance and reduces turnover of direct care workers.
- (6) Possible changes to Medicaid and State/County Special Assistance that could reward direct care workers of providers who achieve NC NOVA special licensure status.

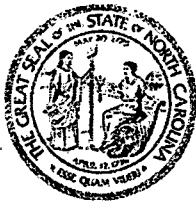


1 (7) Whether individuals receiving unemployment could be trained as direct care
2 workers.

3 (8) Ways the State could encourage an increase in the supply of direct care
4 workers.

5 **SECTION 1.(c)** The Division of Health Service Regulation shall report the results
6 of this study to the North Carolina Study Commission on Aging on or before October 1, 2012.

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



SENATE BILL 450: Direct Care Worker Wage and Benefit Study

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: First Edition

Date: April 1, 2011
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *Senate Bill 450 directs the Division of Health Service Regulation, DHHS, to conduct a study of direct care worker wages and benefits. The bill is a recommendation from the NC Study Commission on Aging.*

[As introduced, this bill was identical to H106, as introduced by Reps. Farmer-Butterfield, Pierce, Weiss, Hurley, which is currently in House Health and Human Services.]

BILL ANALYSIS: Senate Bill 450 requires the Division of Health Service Regulation, DHHS, to coordinate a study of direct care worker wages and benefits and the impact these wages and benefits have on the supply of prospective employees and employee turnover. The Division is required to report the study results to the North Carolina Study Commission on Aging on or before October 1, 2012.

The following elements related to direct care workers should be reviewed during the course of the study:

- (1) Rates of pay and benefits currently offered.
- (2) Direct care worker turnover rates.
- (3) Factors that increase retention of direct care workers.
- (4) An optimal combination of salary and benefits that reduces direct care worker turnover.
- (5) Whether merit pay results in improved job performance and reduces turnover.
- (6) Possible changes to Medicaid and State/County Special Assistance to reward NC NOVA status.
- (7) Whether individuals receiving unemployment could be trained as direct care workers.
- (8) Ways the State could encourage an increase in the supply of direct care workers.

The study group must include the entities listed below.

- Division of Health Service Regulation, DHHS;
- Labor Market Division, ESC;
- Direct Care Workers Assoc. of NC;
- Association for Home and Hospice Care of NC;
- NC Association of Non-Profit Homes for the Aging
- Division of Aging and Adult Services, DHHS;
- NC Board of Nursing;
- NC Hospital Association;
- NC Health Care Facilities Association;
- Division of Medical Assistance, DHHS;
- NC Medical Society;
- NC Assisted Living Association
- NC Association of Long Term Care Facilities;

Senate Bill 450 would become effective when it becomes law.

BACKGROUND: Nurse aides, home care/home health aides, and personal care aides are types of direct care workers who provide hands-on care to individuals who need assistance. Current employers face challenges recruiting and keeping direct care workers and the demand for these workers is estimated to increase as the baby boom generation ages.

The North Carolina Study Commission on Aging was created to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved system of delivery to meet the present and future needs of older adults (G.S. 120-180). Senate Bill 450 is a recommendation from the North Carolina Study Commission on Aging in response to a report on S.L. 2010-69.

S.L. 2010-69 required 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. The study in

Senate Bill 450

Page 2

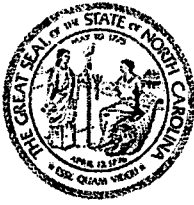
response to S.L. 2010-69 included representatives from the same entities listed for SB 450 with the exception of the Division of Medical Assistance and the Employment Security Commission. The study for S.L. 2010-69 also included representatives from the NC Community College System which SB 450 does not include.

The report on S.L. 2010-69 included a recommendation that the General Assembly consider the establishment of a study focusing on wages and benefits paid to direct care workers. The specific recommendation has been provided below.

3. It has been widely documented that nationally, by 2016, there will be a need for one million additional direct care workers, nurse aides, home care/home health aides and personal care aides to care for aging baby boomers and growing numbers of people with disabilities. Specifically, it is estimated that North Carolina will need an additional 46,000 direct care workers by 2016. This tremendous demand and the challenges employers face in attracting workers to these jobs has lead the Committee to make a specific recommendation to the Study Commission on Aging to address the wage and benefit issues that directly impact supply, retention and high rates of direct care worker turnover in long term care setting. The Committee recommends that the General Assembly consider the establishment of a study focusing on wages and benefits paid to direct care workers and possible improvements to the State's Medicaid and State/County special assistance payment policies that rewards providers who achieve NC NOVA special licensure status.

NC NOVA (New Organizational Vision Award) is a special state license that recognizes workplace excellence in adult care homes, nursing homes, and home care agencies for meeting comprehensive, rigorous standards for front-line caregivers.

S450-SMSH-26(e1) v2



SENATE BILL 451: Extend Reporting on Baby Boomer Preparations

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: First Edition

Date: April 5, 2011
Prepared by: Susan Barham
Research Assistant

SUMMARY: *Senate Bill 451, as recommended by the North Carolina Study Commission on Aging, amends S.L. 2009-407 by outlining the next steps in preparing for the aging baby boomer generation and extends for five years the annual reporting on issues the State needs to address in planning for the increased numbers of older adults.*

[As introduced, this bill was identical to H109, as introduced by Reps. Farmer-Butterfield, Weiss, Pierce, Hurley, which is currently in House Health and Human Services.]

BILL ANALYSIS:

Section 1 of Senate Bill 451 amends Section 1 of S.L. 2009-407 to include other state agencies as applicable to assist in the planning for the aging of the baby boomer generation.

In response to S.L. 2009-407, regional roundtables were held across the State to identify critical issues requiring policy responses. More than 600 individuals participated and each roundtable focused on a different major area relevant to older adults and their families and communities. Section 1 of the bill incorporates the efforts undertaken at the roundtables and outlines the next steps in the process:

- Consolidating information gathered during the 2010 Aging Policy Roundtables, Key Informant Surveys, and the Governor's Conference on Aging into specific issues.
- Identifying future action needed for the most critical issues.
- Prioritizing, on an annual basis, critical issues that are most important for the State to address.

Section 2 of the bill amends Section 2 of S.L. 2009-407 to require annual updates beginning October 1, 2011 through 2015 on the issues the State needs to address in preparation for the aging of the baby boomer generation.

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

BACKGROUND:

S.L. 2009-407, effective August 5, 2009, directed 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 preparing for the increased numbers of older adults. On January 13, 2011, the Study Commission on Aging heard a presentation by Dennis Streets, Director, Division of Aging and Adult Services, on the actions taken in response to S.L. 2009-407.

Because the work to help North Carolina prepare for increased numbers of older adults has only just begun, the Study Commission on Aging recommended, in the Report to the Governor and the 2011 General Assembly, that the General Assembly amend S.L. 2009-407 to extend the annual reporting for five years. The extension also coincides with the time period covered by the State Aging Plan.

S451-SMTE-4(e1) v3

Theresa Matula, Legislative Analyst, contributed to this summary.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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**SENATE BILL 307*
Health Care Committee Substitute Adopted 4/14/11
PROPOSED COMMITTEE SUBSTITUTE S307-PCS85184-TK-9**

Short Title: Smart Card Biometrics Against Medicaid Fraud.

(Public)

Sponsors:

Referred to:

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA SMART CARD PILOT PROGRAM
TO COMBAT FRAUD.

The General Assembly of North Carolina enacts:

SECTION 1. Smart Card Pilot Program. – There is established under the Department of Health and Human Services the North Carolina Smart Card Pilot Program. The pilot program shall be administered by the Provider and Recipient Services Unit of the Division of Medical Assistance. The Department shall determine the scope of the pilot program and may enter into an agreement with a third-party vendor for the purpose of developing and executing the pilot program in accordance with this act. The pilot program shall be initiated for a six- to 12-month period. The pilot program shall involve enrollment, distribution, and use of smart cards by designated recipients as replacements for currently used Medicaid assistance cards.

SECTION 2.(a) The pilot program shall be designed to do all of the following:

- (1) Authenticate recipients at the onset and completion of each point of transaction in order to prevent card sharing and other forms of fraud.
- (2) Deny ineligible persons at the point of transaction.
- (3) Authenticate providers at the point of transaction to prevent phantom billing and other forms of provider fraud.
- (4) Secure and protect the personal identity and information of recipients.
- (5) Reduce the total amount of medical assistance expenditures by reducing the average cost per recipient.

SECTION 2.(b) The pilot program may include all of the following:

- (1) A secure Web-based information system for recording and reporting authenticated transactions.
- (2) A secure Web-based information system that interfaces with the appropriate State databases to determine eligibility of recipients.
- (3) A system that gathers analytical information to be provided to data-mining companies in order to assist in data-mining processes.
- (4) A smart card with the ability to store multiple recipients' information on one card.
- (5) No requirement for preenrollment of recipients.
- (6) An image of the recipient stored on both the smart card and database.



* S 3 0 7 - P C S 8 5 1 8 4 - T K - 9 *

1 **SECTION 2.(c)** In implementing the pilot program, the Department may do the
2 following:

- 3 (1) Incorporate additional or alternative methods of authentication of recipients.
- 4 (2) Enter and store billing codes, deductible amounts, and bill confirmations.
- 5 (3) Allow electronic prescribing services and prescription database integration
6 and tracking in order to prevent medical error through information sharing
7 and to reduce pharmaceutical abuse and lower health care costs.
- 8 (4) Implement quick-pay incentives for providers when electronic prescribing
9 services, electronic health records, electronic patient records, or
10 computerized patient records used by providers automatically synchronize
11 with recipients' smart cards and electronically submit a claim.
- 12 (5) Allow the program, including, but not limited to, smart cards, fingerprint
13 scanners, and card readers, to be adapted for use by other State programs
14 administered by the Department in order to reduce costs associated with the
15 necessity of multiple cards per recipient.

16 **SECTION 2.(d)** The pilot program shall be considered a success if it meets the
17 minimum criteria defined by this act and reduces the average monthly cost of recipients within
18 the pilot program area to recover the cost of the smart card program. In the event that the pilot
19 program does not meet the minimum criteria to be considered a success, the Department may
20 extend and revise the pilot program as necessary and reevaluate the results. In order to evaluate
21 the average monthly cost of recipients within the pilot program and develop the strategy
22 necessary to target the highest rate of savings to the State plan, four sample sets of figures shall
23 be analyzed for the pilot program, including the following:

- 24 (1) Establishment of base figures. – Gather claims data for a first sample set,
25 which shall include all claims for the recipients within the pilot program area
26 and the average cost per recipient by provider type and county from at least
27 the prior year for the exact time period for all areas in the pilot program.
- 28 (2) Adjusted base figures for increase or decrease in cost of services. – In order
29 to evaluate increases or decreases in the cost of services, a second sample set
30 shall be gathered and adjusted to the base figures of the first sample set. The
31 second sample set of claims data shall represent a rural area and an urban
32 area not participating in the pilot program, with as close as possible
33 demographics as the population of recipients in the pilot program areas,
34 including specific data relating to sex, age, race, and ethnicity, county
35 similarities, number of providers, and the average cost per recipient. This
36 sample set shall be analyzed against the prior year's figures and compared to
37 current year figures for the same time frame and area to determine an
38 increase or decrease in cost of services. This sample set shall not have any
39 major changes from the prior year to the current year that would change the
40 comparison, such as the introduction of managed care in the area. The
41 increase or decrease in cost per recipient from this sampling set shall be
42 factored into the data set determined pursuant to subdivision (1) of this
43 subsection to derive an adjusted base figure or average cost per recipient
44 per month.
- 45 (3) Comparison of base figures to current figures. – A third sample set of data
46 shall be gathered reflecting the claims data of the recipients and the average
47 cost per recipient on a monthly basis during the pilot program by provider
48 type. A comparison of the adjusted base figures arrived at by the prior
49 sampling set with the actual figures from this third sample set shall be made
50 to determine how much the State saved by provider type. Recipients leaving
51 the pilot program area to avoid fraud detection will be noted, thus the third

sample set will be adjusted by claims derived outside of the pilot program area.

- (4) Recipient surveying. – A fourth sample set of data shall be obtained by sampling two percent (2%) of Medicaid recipients in the pilot program area and shall be surveyed prior to the start of the pilot program to acknowledge services used, frequency of services used, and satisfaction of services used. This survey shall be taken again at the completion of the pilot program to rate the level of satisfaction of the pilot program.

SECTION 2.(e) The pilot program shall not be expanded unless the Department's data indicates that the program can be expanded through program savings. During the pilot program, the Department may consider the feasibility of expanding the pilot program, including the need to develop rules and policies related to the following:

- (1) The handling of lost, forgotten, or stolen cards.
- (2) Enrolling all recipients, regardless of age, for participation in the program.
- (3) Distributing and activating smart cards for designated recipients.

SECTION 2.(f) The Department shall work with the Division of Motor Vehicles to ensure that State data, such as drivers license photos and other identification data, is leveraged to reduce program cost.

SECTION 3. Reports. – By June 30, 2012, the Department shall submit a detailed written report on the implementation and success of the smart card pilot program to the Governor, to the Speaker of the House of Representatives, to the President Pro Tempore of the Senate, to the Chairs of the Senate and House of Representatives Appropriations Committees, and to the Fiscal Research Division.

SECTION 4. Compliance. – This act shall be construed consistent with the federal Social Security Act, and any provision of this article found to be in conflict with the federal Social Security Act shall be deemed to be void and of no effect. If before implementing any provision of this act, the Department determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the Department shall request the waiver or authorization as soon as practicable.

SECTION 5. Prosecutions. – All federal and State laws regulating the privacy of personal health information, including the Health Insurance Portability and Accountability Act of 1998 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act shall apply. If, in connection with the pilot program, the Department has reason to believe medical assistance fraud has been committed, the Department shall refer such matters to the Attorney General for prosecution, as appropriate. Prosecutions can involve both criminal and civil penalties allowable under law, up to a felony criminal conviction.

SECTION 6. Contracts. – Sections 4 and 5 of this act shall apply to all contracts made by the Department in regard to this pilot program. All compliance and prosecution provisions in this act shall be incorporated into all contracts, subcontracts, and any other contractual documents created between the Department and a third-party vendor. All contracting parties will be subject to all applicable federal and State laws and will be subject to prosecution if there is any violation of federal or State laws with regard to privacy of personal health information. The Department, if acting in good faith, shall not be held responsible for any action of any contractor or subcontractor in the event that that contractor or subcontractor violates any federal or State laws regarding the protection of personal health information.

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

PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 4-20 TIME: 11 ^{AM}

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
¹ ~~Allie Drexler~~ ^{David Gravitt}	~~Raleigh~~ King	~~Neat Hunt~~ East
Alex Ioftin	Wilmington	Groomsby
³ Brittanie Kelly	Raleigh	Blue
⁴ Zachary Dale	Cary	Bingham
⁵ Robert Musselwhite	New Bern	Preston
⁶ Kristen Johnson	Cary	Blue
~~⁷ Nathan Fisher~~	~~Charlotte~~	~~Rochs~~
⁸		
⁹		
¹⁰		

Do not add names below the grid.

VISITOR REGISTRATION SHEET

HEALTH CARE

April 20, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark DA	Smith Anderson
SPUR GREGON, MD	White Forest Bayview
Steve Mitchell	Astellas
TINA GORDON	NC Nurses
DAVID Holbrook	NC Board of Nursing
ZEB ALLEY	NMRS
Mami Wolden	Government
Chris Killian	Nelson Mullins
DAVID BARNES	PS
Lu. Anderson	CSS
Joe Wild	WCHTC #

VISITOR REGISTRATION SHEET

HEALTH CARE

April 20, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby Emanuelson	NMSS - NC
Betsy Vetter	American Heart Assn
Paul Hagler	Infon
Rian Ellis	NC Center for Public Policy Research
Joanne Stevens	NCHA / Stevens lobby
Frank Bomm	Bomm Assoc.
DELL MUMFORD	ERM & ASSOC.
REYTON MUMFORD	" ↓ "
Teresa Johnson	NC Adult Day Services Assn.
Kaye McGinty	ECU - BSOM
Ornella Potter	ECU - BSOM
Chuck [Signature]	SEANC
Erilyn [Signature]	ETGR

VISITOR REGISTRATION SHEET

HEALTH CARE

April 20, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Jerme Gibson	ECH-BSDM
Eric Meekar	ECH-BSDM
Kay Paksoy	NASW-NC
Nicole Fisher	John Locke Foundation
Susan DeLaney	NCANP
Michael Smith	NCANP
Christopher McNally	NCANP
Robert McNelly	NCANP
Ledya Fystra	Duke, NCPA
Joseph Criss	Duke, NCPA

VISITOR REGISTRATION SHEET

HEALTH CARE

Name of Committee

April 20, 2011

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME**FIRM OR AGENCY AND ADDRESS**

Mary Beth

AA2 - Ne

Erica Nelson

NCCCP

Kris Horner

CHHS

VISITOR REGISTRATION SHEET

HEALTH CARE

April 20, 2011

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOHN GILMORE	UNC, NC Psychiatric Assn.
John Diamond	ECU & NC Psychiatric Assn.
Allan Chrisman, MD	Duke, NC PA
Matt Wolfe	Parker Poe
Joseph Peters	JR Assoc.
Dean Plunkett	PS
Amy White	NC med society
Mark H. Garner	Carolina's Healthcare System
WM	WM
Bl Miller	Moses Cove
Don Hoffman	NC Psychiatric Assn.

SENATE HEALTH CARE COMMITTEE

April 27, 2011

MINUTES

The Senate Health Care Committee met on Wednesday, March 16, 2011 in Room 544 of the Legislative Office Building. Thirteen members were in attendance along with staff Shawn Parker, Theresa Matula, Amy Jo Johnson, and Susan Barham.

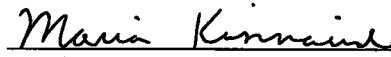
Senator Bingham called the meeting to order at 11:09am and introduced the Pages. Senator Forrester made a motion to consider the Proposed Committee Substitute for Senate Bill 246, AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF IMMUNIZING PHARMACISTS. The motion carried and the bill's sponsor, Senator Hartsell explained the bill. Senator Tucker made a motion to allow audience members to speak on the bill. Dr. Brian Forrest of the Academy of Family Physicians of Apex, NC spoke from the audience. After further discussion, the bill was tabled.

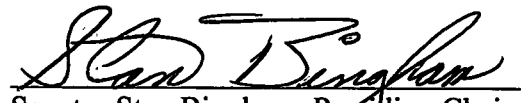
The next bill to be considered was Senate Bill 608, AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE HEALTH INSURANCE REGULATORY LAWS. The bill was sponsored and explained by Senator Hunt. After discussion and questions, Senator Rucho made a motion for a favorable report. The motion carried and the report was favorable as to the bill.

A motion was made to consider the Proposed Committee Substitute for Senate Bill 607, AN ACT TO CONFORM MEDICAL RECORD CONFIDENTIALITY LAWS. The motion carried and the bill's sponsor, Senator Stein explained the bill. Several audience members were recognized to speak on the bill. They were Rob Lamme and Fred Zufelt of CCNC, Annaliese Dolph of Disability Rights NC, Debi Dihoff of NAMI and Mark Batz of the UNC School of Government. After questions and discussion, Senator Pate made a motion for a favorable report. The motion carried and the report was unfavorable as to bill, but favorable as to committee substitute bill.

The meeting was adjourned at 11:52am.

Respectfully submitted,


Maria Kinnaid, Committee Assistant


Senator Stan Bingham, Presiding Chair

Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Principal Clerk
Reading Clerk

Corrected:

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 27, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 608	Health Care Sharing Organizations.	Senator Hunt
SB 607	Conform Medical Record Laws.	Senator Stein
SB 718	Prescription Integrity Act.	Senator Mansfield
SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee
Wednesday, April 27, 2011, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 608	Health Care Sharing Organizations.	Senator Hunt
SB 607	Conform Medical Record Laws.	Senator Stein
SB 718	Prescription Integrity Act.	Senator Mansfield
SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, April 27, 2011

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

FAVORABLE

S.B.	608	Health Care Sharing Organizations.	
		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 Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Thursday, April 28, 2011

Senator BINGHAM,

submits the following with recommendations as to passage:

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

S.B.	607	Conform Medical Record Laws.	
		Draft Number:	95082
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 246
PROPOSED COMMITTEE SUBSTITUTE S246-CSSQ-8 [v.4]

4/21/2011 2:05:43 PM

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors:

Referred to:

March 8, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
3 IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
4 IMMUNIZING PHARMACISTS.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. G.S. 90-85.3 is amended by adding the following new subsections to
7 read:

8 "(i1) "Immunizing pharmacist" means a licensed pharmacist who meets all of the
9 following qualifications:

- 10 (1) Holds a current provider level cardiopulmonary resuscitation certification
11 issued by the American Heart Association or the American Red Cross, or an
12 equivalent certification.
13 (2) Has successfully completed a certificate program in vaccine administration
14 accredited by the Centers for Disease Control and Prevention, the
15 Accreditation Council for Pharmacy Education, or a similar health authority
16 or professional body approved by the Board.
17 (3) Maintains documentation of three hours of continuing education every two
18 years, designed to maintain competency in the disease states, drugs, and
19 vaccine administration.
20 (4) Has successfully completed training approved by the Division of Public
21 Health's Immunization Branch for participation in the North Carolina
22 Immunization Registry.
23 (5) Administers vaccines or immunizations in accordance with G.S. 90-18.15B."

24 SECTION 2. G.S. 90-85.3 is amended by adding the following new subsections to
25 read:

26 "(v) "Written Protocol" means a written order, standing medical order, or other order or
27 protocol. A written protocol shall be prepared, signed and dated by the physician and
28 pharmacist and containing all of the following information:

- 29 (1) The name of the individual physician authorized to prescribe drugs and
30 responsible for authorizing the written protocol.
31 (2) The name of the individual pharmacist authorized to administer vaccines.
32 (3) The immunizations or vaccinations that may be administered by the
33 pharmacist.



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- (4) Procedures to follow, including any drugs required by the pharmacist for treatment of the patient, in the event of an emergency or severe adverse reaction following vaccine administration.
- (5) The reporting requirements by the pharmacist to the physician issuing the written protocol, including content and time frame.
- (6) Locations at which the pharmacist may administer immunizations or vaccinations.
- (7) The requirement for annual review of the protocols by the physician and pharmacist.

SECTION 2. G.S. 90-85.3(r) reads as rewritten:

"(r) "Practice of pharmacy" means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4, as specified in G.S. 90-85.3A."

SECTION 3. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.3A. Practice of pharmacy.

(a) A pharmacist is responsible for interpreting and evaluating drug orders, including prescription orders; compounding, dispensing, and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services.

(b) A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses, and significant problems of drugs and devices; assess, record, and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record, and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

(c) A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the following: The Board of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(d) An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.

SECTION 4. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.15B Immunizing pharmacists

(a) An immunizing pharmacist may administer vaccines or immunizations recommended or required by the Centers for Disease Control and Prevention, including

vaccines recommended or required for travel outside the United States, with the following limitations:

- (1) Vaccines or immunizations shall not be administered to patients under the age of seven.
- (2) For patients at least seven years of age, but less than 14 years of age, influenza vaccines shall only be administered (i) pursuant to written protocol, and (ii) at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.
- (3) For patients at least seven years of age, but less than 14 years of age, vaccines or immunizations other than influenza vaccine shall only be administered (i) pursuant to a specific prescription order, (ii) pursuant to written protocol, and (iii) at the request of the patient's parent, guardian, or person standing in loco parentis to the minor.
- (4) For patients at least 14 years of age, but less than 18 years of age, vaccines or immunizations shall be administered pursuant to written protocol, at the request of the of the patient's parent, guardian, or person standing in loco parentis to the minor either with or without a specific prescription order.
- (5) For patients at least 18 years of age, vaccines or immunizations shall be administered pursuant to written protocol, at the request of the patient either with or without a specific prescription order.

(b) An immunizing pharmacist who administers a vaccine or immunization to any patient pursuant to this section shall do all of the following:

- (1). Maintain a record of any vaccine or immunization administered to the patient in a patient profile.
- (2). If the patient has identified a primary care provider, notify the patient's primary care provider of any vaccine or immunization administered to the patient within 24 hours after administration.
- (3). Record any vaccine or immunization administered to the patient in the North Carolina Immunization Registry within 24 hours after administration."

SECTION 5. G.S. 130A-153 reads as rewritten:

"(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or from~~ medicine; a local health ~~department~~ department; or an immunizing pharmacist, in accordance with the provisions of G.S. 90-85.15B. Local health departments shall administer required and State-supplied immunizations at no cost to uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health departments, immunizing pharmacist, and the patient's attending physician. In addition, an insurance institution, agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may share immunization information with the Department. The Commission may, for the purpose of assisting the Department in enforcing this Part, provide by rule that other persons may have access to immunization information, in whole or in part.

(d) A ~~physician~~ physician, immunizing pharmacist, or local health department may immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A ~~physician~~ physician, immunizing pharmacist, or local health department may also immunize a minor who is presented for immunization by an adult who signs a statement that he

1 or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to
2 obtain the immunization for the minor. Notwithstanding any other provision of this Chapter, an
3 immunizing pharmacist's authority to administer vaccines or immunizations to a minor is
4 limited to the authority specified in G.S. 90-85.15B."

5 **SECTION 6.** G.S. 130A-154(a) reads as rewritten:

6 "(a) A ~~physician~~physician, immunizing pharmacist, or local health department
7 administering a required vaccine shall give a certificate of immunization to the person who
8 presented the child for immunization. The certificate shall state the name of the child, the name
9 of the child's parent, guardian, or person responsible for the child obtaining the required
10 immunization, the address of the child and the parent, guardian or responsible person, the date
11 of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the
12 doses were given, the name and address of the ~~physician~~physician, immunizing pharmacist, or
13 local health department administering the required immunization and other relevant
14 information required by the Commission."

15 **SECTION 7.** This act becomes effective October 1, 2011.



SENATE BILL 246: Expand Pharmacists' Immunizing Authority

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S246-CSSQ-8

Date: April 26, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *The Proposed Committee Substitute to Senate Bill 246 authorizes an "immunizing pharmacist" (defined term) to administer certain vaccines or immunizations pursuant to written protocol with additional restrictions based on vaccine type or patient age.*

CURRENT LAW: Currently a pharmacist who has received special training is permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by the Board of Pharmacy, Board of Nursing, and Board of Medicine.

The current rule provides standards for pharmacists engaged in the administration of influenza, pneumococcal and zoster vaccines for persons 18 years and older.

BILL ANALYSIS: Senate Bill 246 amends the Pharmacy Practice Act as follows:

Section 1 defines the term "immunizing pharmacist" as a licensed pharmacist who holds a current CPR certification, completed a certificate program in vaccine administration, maintains documentation of continuing education in vaccine administration, has successfully completed training for participation in the NC Immunization Registry and administers vaccines or immunizations in accordance with the Article.

The section further codifies the current definition of the term "written protocol" from 21 NCAC 46 .2507 to provide for its use under the Act.

Sections 2 and 3 recodify the definition of the practice of pharmacy as a new section G.S. 90-85.3A.

Section 4 authorizes an immunizing pharmacist to administer vaccines or immunizations recommended or required by the CDC including those recommended or required for travel outside of the United States with the following limitations:

Age	Not Administered	Administered Pursuant to Written Protocol	At the Request of:	Specific Prescription Order
Under 7 Years Old	X		N/A	N/A
At Least 7 < 14 Years Old (Flu Vaccine)		X	Parent/Guardian	N/A
At Least 7 < 14 Years Old (Vaccines other than Flu)		X	Parent/Guardian	With
At Least 14 < 18 Years Old		X	Parent/Guardian	With or Without
At Least 18 Years Old		X	Patient	With or Without

Senate PCS 246

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and requires an immunizing pharmacist who administers vaccines or immunizations to do the following:

- Maintain a record of the vaccine or immunization administered in the patient profile.
- Notify the primary care provider (if the patient so identifies) within 24 hours of the administration.
- Record any vaccine or immunization in the NC Immunization Registry within 24 hours of the administration.

Sections 5-6 make conforming changes in the public health law to provide for an immunizing pharmacist.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S246-SMSQ-18(CSSQ-8) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 246

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors: Senators Hartsell; Atwater and Mansfield.

Referred to: Health Care.

March 8, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
3 IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
4 IMMUNIZING PHARMACISTS.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. G.S. 90-85.3(r) reads as rewritten:

7 "(r) "Practice of pharmacy" ~~means the responsibility for: interpreting and evaluating~~
8 ~~drug orders, including prescription orders; compounding, dispensing and labeling prescription~~
9 ~~drugs and devices; properly and safely storing drugs and devices; maintaining proper records;~~
10 ~~and controlling pharmacy goods and services. A pharmacist may advise and educate patients~~
11 ~~and health care providers concerning therapeutic values, content, uses and significant problems~~
12 ~~of drugs and devices; assess, record and report adverse drug and device reactions; take and~~
13 ~~record patient histories relating to drug and device therapy; monitor, record and report drug~~
14 ~~therapy and device usage; perform drug utilization reviews; and participate in drug and drug~~
15 ~~source selection and device and device source selection as provided in G.S. 90-85.27 through~~
16 ~~G.S. 90-85.31. A pharmacist who has received special training may be authorized and~~
17 ~~permitted to administer drugs pursuant to a specific prescription order in accordance with rules~~
18 ~~adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina~~
19 ~~Medical Board. The rules shall be designed to ensure the safety and health of the patients for~~
20 ~~whom such drugs are administered. An approved clinical pharmacist practitioner may~~
21 ~~collaborate with physicians in determining the appropriate health care for a patient, subject to~~
22 ~~the provisions of G.S. 90-18.4.~~ is as specified in G.S. 90-85.3A."

23 SECTION 2. Article 4A of Chapter 90 of the General Statutes is amended by
24 adding a new section to read:

25 "§ 90-85.3A. Practice of pharmacy.

26 (a) A pharmacist is responsible for interpreting and evaluating drug orders, including
27 prescription orders; compounding, dispensing, and labeling prescription drugs and devices;
28 properly and safely storing drugs and devices; maintaining proper records; and controlling
29 pharmacy goods and services.

30 (b) A pharmacist may advise and educate patients and health care providers concerning
31 therapeutic values, content, uses, and significant problems of drugs and devices; assess, record,
32 and report adverse drug and device reactions; take and record patient histories relating to drug
33 and device therapy; monitor, record, and report drug therapy and device usage; perform drug
34 utilization reviews; and participate in drug and drug source selection and device and device
35 source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

36 (c) A pharmacist who has received special training may be authorized and permitted to
37 administer drugs pursuant to a specific prescription order in accordance with rules adopted by



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each of the following: The Board of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(d) An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.

(e) A pharmacist who (i) holds a current provider level cardiopulmonary resuscitation certification issued by the American Heart Association or the American Red Cross, or an equivalent certification, (ii) has successfully completed a certificate program in vaccine administration accredited by the Centers for Disease Control and Prevention, the Accreditation Council for Pharmacy Education, or a similar health authority or professional body approved by the Board, (iii) maintains documentation of three hours of continuing education every two years, designed to maintain competency in the disease states, drugs, and vaccine administration, and (iv) has successfully completed training approved by the Division of Public Health's Immunization Branch for participation in the North Carolina Immunization Registry may administer any vaccine or immunization recommended or required by the Centers for Disease Control and Prevention, including a vaccine for travel outside the United States, subject to the following limitations and requirements:

(1) A pharmacist may administer a vaccine or immunization to a minor who is at least seven years of age, but less than 14 years of age, only (i) pursuant to a specific prescription order and (ii) at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.

(2) A pharmacist may administer a vaccine or immunization without a specific prescription order to a minor who is at least 14 years of age, but less than 18 years of age, only at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.

(3) A pharmacist may administer a vaccine or immunization without a specific prescription order to any patient 18 years of age or older, at the patient's request.

(4) A pharmacist who administers a vaccine or immunization to any patient pursuant to this subsection shall do all of the following:

a. Maintain a record of any vaccine or immunization administered to the patient in a patient profile.

b. If the patient has identified a primary care provider, notify the patient's primary care provider of any vaccine or immunization administered to the patient within 24 hours after administration.

c. Record any vaccine or immunization administered to the patient in the North Carolina Immunization Registry within 24 hours after administration."

SECTION 3. G.S. 130A-153 reads as rewritten:

"(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or from~~ medicine; a local health ~~department~~ department; or a pharmacist, in accordance with the provisions of G.S. 90-85.3A(e). Local health departments shall administer required and State-supplied immunizations at no cost to uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health

1 departments, a pharmacist administering the required immunization in accordance with
2 G.S. 90-85.3A(e), and the patient's attending physician. In addition, an insurance institution,
3 agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may
4 share immunization information with the Department. The Commission may, for the purpose of
5 assisting the Department in enforcing this Part, provide by rule that other persons may have
6 access to immunization information, in whole or in part.

7 (d) A ~~physician~~physician, pharmacist, or local health department may immunize a
8 minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A
9 ~~physician~~physician, pharmacist, or local health department may also immunize a minor who is
10 presented for immunization by an adult who signs a statement that he or she is authorized by a
11 parent, guardian, or person standing in loco parentis to the minor to obtain the immunization
12 for the minor. Notwithstanding any other provision of this Chapter, a pharmacist's authority to
13 administer vaccines or immunizations to a minor is limited to the authority specified in
14 G.S. 90-85.3A(e)."

15 **SECTION 4.** G.S. 130A-154(a) reads as rewritten:

16 "(a) A ~~physician~~physician, pharmacist, or local health department administering a
17 required vaccine shall give a certificate of immunization to the person who presented the child
18 for immunization. The certificate shall state the name of the child, the name of the child's
19 parent, guardian, or person responsible for the child obtaining the required immunization, the
20 address of the child and the parent, guardian or responsible person, the date of birth of the
21 child, the sex of the child, the number of doses of the vaccine given, the date the doses were
22 given, the name and address of the ~~physician~~physician, pharmacist, or local health department
23 administering the required immunization and other relevant information required by the
24 Commission."

25 **SECTION 5.** This act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 608*

Short Title: Health Care Sharing Organizations.

(Public)

Sponsors: Senators Hunt; Allran, Blake, Forrester, Rabon, Soucek, and Tillman.

Referred to: Health Care:

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO EXEMPT HEALTH CARE SHARING ORGANIZATIONS FROM THE
HEALTH INSURANCE REGULATORY LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 49 of Chapter 58 of the General Statutes is amended by
adding a new section to read:

"§ 58-49-12. Exceptions to jurisdiction; health care sharing organizations.

**A health care sharing organization shall not be subject to the jurisdiction of the
Commissioner and shall not be considered to be engaging in the business of providing health
care benefits as long as the health care sharing organization does the following:**

- (1) Maintains nonprofit entity status under the Internal Revenue Code.**
- (2) Limits its participants to those who share similar interests as defined by the
organization.**
- (3) Provides for the financial or medical needs of a participant through
contributions from one participant to another in accordance with criteria
established by the health care sharing organization.**
- (4) Provides amounts that participants may contribute with no assumption of
risk or promise to pay among the participants and no assumption of risk or
promise to pay by the health care sharing organization to the participants.**
- (5) Publishes a written monthly statement to all participants that lists the total
dollar amount of qualified needs submitted to the health care sharing
organization, as well as the amount published or assigned to participants for
their contribution.**
- (6) Provides a written disclaimer on or accompanying all applications and
guideline materials distributed by or on behalf of the organization that reads,
in substance, as follows:**

**NOTICE: The organization facilitating the sharing of medical
expenses is not an insurance company and neither its guidelines nor
its plan of operation is an insurance policy. Whether anyone chooses
to assist you with your medical bills will be voluntary. No other
participant will be compelled by law to contribute toward your
medical bills. As such, participation in the organization or a
subscription to any of its documents should never be considered to be
insurance. Regardless of whether you receive any payment for
medical expenses or whether this organization continues to operate,
you are always personally liable for the payment of your own
medical bills."**



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SECTION 2. This act becomes effective October 1, 2011.



SENATE BILL 608: Health Care Sharing Organizations

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hunt
Analysis of: First Edition

Date: April 25, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 608 exempts health care sharing organizations from the health insurance regulatory laws.*

[As introduced, this bill was identical to H578, as introduced by Reps. Murry, Dockham, Barnhart, which is currently in House Insurance.]

CURRENT LAW: Health care sharing organizations are not currently regulated by the Commissioner of Insurance.

BILL ANALYSIS: Senate Bill 608 adds a new section to Article 49 of Chapter 58 of the General Statutes which exempts health care sharing organizations from the jurisdiction of the Commissioner of Insurance. A health care sharing organization will not be considered to be engaging in the business of providing health care benefits. In order to be exempt from the health insurance regulatory laws, the health care sharing organization must do the following:

- Maintain nonprofit entity status
- Limit its participants to persons sharing similar interests
- Provide for the financial or medical needs of its participants through participant contributions
- Provide amounts that participants may contribute with no assumption of risk or promise to pay among participants
- Assume no risk or promise to pay to the participants of the health care sharing organization
- Publish a written monthly statement to all participants listing the total dollar amount of qualified needs submitted to the health care sharing organization and the amount assigned to its participants for their contribution
- Provide a written disclaimer on or accompanying all applications and guideline materials that reads, in substance, as follows:

NOTICE: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor its plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be voluntary. No other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally liable for the payment of your own medical bills.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S608-SMTK-21(e1) v3

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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D

SENATE BILL 607*
PROPOSED COMMITTEE SUBSTITUTE S607-CSSQ-17 [v.1]

4/25/2011 2:08:01 PM

Short Title: Conform Medical Record Laws.

(Public)

Sponsors:

Referred to:

April 19, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO CONFORM MEDICAL RECORD CONFIDENTIALITY LAWS.
3 The General Assembly of North Carolina enacts:

4 SECTION 1. G.S. 90-85.36 reads as rewritten:

5 "§ 90-85.36. Availability of pharmacy records.

6 (a) Except as provided in subsections (b) and (c) below, written or electronic
7 prescription orders on file in a pharmacy or other place where prescriptions are dispensed are
8 not public records and any person having custody of or access to the prescription orders may
9 divulge the contents or provide a copy only to the following persons:

- 10 (1) An adult patient for whom the prescription was issued or a person who is
11 legally appointed guardian of that person;
12 (2) An emancipated minor patient for whom the prescription order was issued or
13 a person who is the legally appointed guardian of that patient;
14 (3) An unemancipated minor patient for whom the prescription order was issued
15 when the minor's consent is sufficient to authorize treatment of the condition
16 for which the prescription was issued;
17 (4) A parent or person in loco parentis of an unemancipated minor patient for
18 whom the prescription order was issued when the minor's consent is not
19 sufficient to authorize treatment for the condition for which the prescription
20 is issued;
21 (5) The licensed practitioner who issued the prescription;
22 (6) The licensed practitioner who is treating the patient for whom the
23 prescription was issued;
24 (7) A pharmacist who is providing pharmacy services to the patient for whom
25 the prescription was issued;
26 (8) Anyone who presents a written authorization for the release of pharmacy
27 information signed by the patient or his legal representative;
28 (9) Any person authorized by subpoena, court order or statute;
29 (10) Any firm, association, partnership, business trust, corporation or company
30 charged by law or by contract with the responsibility of providing for or
31 paying for medical care for the patient for whom the prescription order was
32 issued;
33 (11) A member or designated employee of the Board;



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- 1 (12) The executor, administrator or spouse of a deceased patient for whom the
2 prescription order was issued;
- 3 (13) Researchers and surveyors who have approval from the Board. The Board
4 shall issue this approval when it determines that there are adequate
5 safeguards to protect the confidentiality of the information contained in the
6 prescription orders and that the researchers or surveyors will not publicly
7 disclose any information that identifies any person; or
- 8 (14) The person owning the pharmacy or his authorized agent; ~~agent; or~~
- 9 (15) A HIPAA covered entity or a health care provider who is not a covered
10 entity for purposes of treatment, payment, or health care operations to the
11 extent that disclosure is permitted or required by applicable State or federal
12 law.

13 (b) A pharmacist may disclose any information to any person only when he reasonably
14 determines that the disclosure is necessary to protect the life or health of any person.

15 (c) Records required to be kept by G.S. 90-93(d) (Schedule V) are not public records
16 and shall be disclosed at the pharmacist's discretion."

17 **SECTION 2. G.S. 122C-55 reads as rewritten:**

18 **"§ 122C-55. Exceptions; care and treatment.**

19 (a) ~~Any area or State facility or the psychiatric service of the University of North~~
20 ~~Carolina Hospitals at Chapel Hill may share confidential information regarding any client of~~
21 ~~that facility with any other area or State facility or the psychiatric service of the University of~~
22 ~~North Carolina Hospitals at Chapel Hill when necessary to coordinate~~provide appropriate and
23 effective care, treatment or habilitation of the client. For the purposes of this ~~subsection,~~section,
24 ~~coordinate~~provide means the provision, coordination, or management of mental health,
25 developmental disabilities, and substance abuse services and related services by one or more
26 facilities and includes the referral of a client from one facility to another.

27 (a1) Any facility may share confidential information regarding any client of that facility
28 with the Secretary, and the Secretary may share confidential information regarding any client
29 with a facility when necessary to conduct quality assessment and improvement activities or to
30 ~~coordinate~~provide appropriate and effective care, treatment or habilitation of the client. For
31 purposes of this ~~subsection,~~subsection, subsection (a6), and subsection (a6)(a7) of this section,
32 the purposes or activities for which confidential information may be used and disclosed
33 include, but are not limited to, case management and care coordination, disease management,
34 outcomes evaluation, the development of clinical guidelines and protocols, the development of
35 care management plans and systems, population-based activities relating to improving or
36 reducing health care costs, and the provision, coordination, or management of mental health,
37 developmental disabilities, and substance abuse services and other health or related services. As
38 used in this section, "facility" includes an LME and "Secretary" includes the Department's
39 Community Care of North Carolina Program or other primary care case management programs
40 that contract with the Department to provide a primary care case management program for
41 recipients of publicly funded health and related services.

42 (a2) Any area or State facility or the psychiatric service of the University of North
43 Carolina Hospitals at Chapel Hill may share confidential information regarding any client of
44 that facility with any other area facility or State facility or the psychiatric service of the
45 University of North Carolina Hospitals at Chapel Hill when necessary to conduct payment
46 activities relating to an individual served by the facility. Payment activities are activities
47 undertaken by a facility to obtain or provide reimbursement for the provision of services and
48 may include, but are not limited to, determinations of eligibility or coverage, coordination of
49 benefits, determinations of cost-sharing amounts, claims management, claims processing,
50 claims adjudication, claims appeals, billing and collection activities, medical necessity reviews,
51 utilization management and review, precertification and preauthorization of services,

1 concurrent and retrospective review of services. and appeals related to utilization management
2 and review.

3 (a3) Whenever there is reason to believe that a client is eligible for benefits through a
4 Department program, any State or area facility or the psychiatric service of the University of
5 North Carolina Hospitals at Chapel Hill may share confidential information regarding any
6 client of that facility with the Secretary, and the Secretary may share confidential information
7 regarding any client with an area facility or State facility or the psychiatric services of the
8 University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information
9 necessary to establish initial eligibility for benefits, determine continued eligibility over time,
10 and obtain reimbursement for the costs of services provided to the client.

11 (a4) An area authority or county program may share confidential information regarding
12 any client with any area facility, and any area facility may share confidential information
13 regarding any client of that facility with the area authority or county program, when the area
14 authority or county program determines the disclosure is necessary to develop, manage,
15 monitor, or evaluate the area authority's or county program's network of qualified providers as
16 provided in G.S. 122C-115.2(b)(1) b., G.S. 122C-141(a), the State Plan, and rules of the
17 Secretary. For the purposes of this subsection, the purposes or activities for which confidential
18 information may be disclosed include, but are not limited to, quality assessment and
19 improvement activities, provider accreditation and staff credentialing, developing contracts and
20 negotiating rates, investigating and responding to client grievances and complaints, evaluating
21 practitioner and provider performance, auditing functions, on-site monitoring, conducting
22 consumer satisfaction studies, and collecting and analyzing performance data.

23 (a5) Any area facility may share confidential information with any other area facility
24 regarding an applicant when necessary to determine whether the applicant is eligible for area
25 facility services. For the purpose of this subsection, the term "applicant" means an individual
26 who contacts an area facility for services.

27 (a6) When necessary to conduct quality assessment and improvement activities or to
28 ~~coordinate~~ provide appropriate and effective care, treatment, or habilitation of the client, a
29 ~~DHHS primary care case manager~~ the Department's Community Care of North Carolina
30 Program, or other primary care case management program, may disclose confidential
31 information acquired pursuant to subsection (a1) of this section to a health care provider or
32 other entity that has entered into a written agreement with the Department's Community Care of
33 North Carolina Program, or other primary care case management program, to participate in the
34 care management support network and systems developed and maintained ~~by the primary care~~
35 ~~case manager~~ for the purpose of coordinating and improving the quality of care for recipients of
36 publicly funded health and related services. Health care providers and other entities receiving
37 confidential information from the Department's Community Care of North Carolina Program or
38 other primary care case management program pursuant to this subsection may use and disclose
39 the information ~~as authorized by G.S. 122C-53 through G.S. 122C-56 or as permitted or~~
40 ~~required by other applicable State or federal law when necessary to conduct quality assessment~~
41 and improvement activities or to provide appropriate and effective care, treatment, or
42 habilitation of the client.

43 (a7) A facility may share confidential information with one or more health care providers
44 that are covered entities for the same purposes set forth in subsection (a1) of this section.
45 Before making disclosures under this subsection, the facility shall inform the client that the
46 facility may make such disclosures unless the client objects in writing. If the client objects in
47 writing, the disclosures otherwise permitted by this subsection are prohibited. A covered entity
48 receiving confidential information from a facility under this subsection may use and disclose
49 the information when necessary to conduct quality assessment and improvement activities or to
50 provide appropriate and effective care, treatment, or habilitation of the client. For the purposes

of this subsection. the terms 'covered entity' and 'health care provider' have the meaning given those terms in 45 Code of Federal Regulations § 160.103.

...."

SECTION 3. G.S. 130A-12 reads as rewritten:

"§ 130A-12. Confidentiality of records.

All records containing privileged patient medical information, information protected under 45 Code of Federal Regulations Parts 160 and 164, and information collected under the authority of Part 4 of Article 5 of this Chapter that are in the possession of the Department of Health and Human Services, the Department of Environment and Natural Resources, or local health departments shall be confidential and shall not be public records pursuant to G.S. 132-1. Information contained in the records may be disclosed only when disclosure is authorized or required by State or federal law. Notwithstanding ~~G.S. 8-53 or G.S. 130A-143, G.S. 8-53~~, the information contained in the records may be disclosed for purposes of treatment, payment, ~~research~~, or health care operations operations to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i). For purposes of this section, the terms "treatment," "payment," "research," and "health care operations" have the meanings given those terms in 45 Code of Federal Regulations § 164.501."

SECTION 4. G.S. 130A-143 reads as rewritten:

"§ 130A-143. Confidentiality of records.

All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. This information shall not be released or made public except under the following circumstances:

- (1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified;
- (2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardian;
- (3) Release is made ~~to health care personnel providing medical care to the patient; for purposes of treatment, payment, research, or health care operations to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i).~~ to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i). For purposes of this section, the terms 'treatment,' 'payment,' 'research' and 'health care operations' have the meaning given those terms in 45 Code of Federal Regulations § 164.501;
- (4) Release is necessary to protect the public health and is made as provided by the Commission in its rules regarding control measures for communicable diseases and conditions;
- (5) Release is made pursuant to other provisions of this Article;
- (6) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties and those engaged in the trial of the case;
- (7) Release is made by the Department or a local health department to a court or a law enforcement official for the purpose of enforcing this Article or Article 22 of this Chapter, or investigating a terrorist incident using nuclear, biological, or chemical agents. A law enforcement official who receives the information shall not disclose it further, except (i) when necessary to enforce this Article or Article 22 of this Chapter, or when necessary to conduct an investigation of a terrorist incident using nuclear, biological, or chemical agents, or (ii) when the Department or a local health department seeks the assistance of the law enforcement official in preventing or controlling the

- 1 spread of the disease or condition and expressly authorizes the disclosure as
2 necessary for that purpose;
- 3 (8) Release is made by the Department or a local health department to another
4 federal, state or local public health agency for the purpose of preventing or
5 controlling the spread of a communicable disease or communicable
6 condition;
- 7 (9) Release is made by the Department for bona fide research purposes. The
8 Commission shall adopt rules providing for the use of the information for
9 research purposes;
- 10 (10) Release is made pursuant to G.S. 130A-144(b); or
11 (11) Release is made pursuant to any other provisions of law that specifically
12 authorize or require the release of information or records related to AIDS."

13 **SECTION 5. G.S. 131D-21 reads as rewritten:**

14 **"§ 131D-21. Declaration of residents' rights.**

15 Each facility shall treat its residents in accordance with the provisions of this Article. Every
16 resident shall have the following rights:

- 17 (1) To be treated with respect, consideration, dignity, and full recognition of his
18 or her individuality and right to privacy.
- 19 (2) To receive care and services which are adequate, appropriate, and in
20 compliance with relevant federal and State laws and rules and regulations.
- 21 (3) To receive upon admission and during his or her stay a written statement of
22 the services provided by the facility and the charges for these services.
- 23 (4) To be free of mental and physical abuse, neglect, and exploitation.
- 24 (5) Except in emergencies, to be free from chemical and physical restraint
25 unless authorized for a specified period of time by a physician according to
26 clear and indicated medical need.
- 27 (6) To have his or her personal and medical records kept confidential and not
28 disclosed ~~without the written consent of the individual or guardian, which~~
29 ~~consent shall specify to whom the disclosure may be made, except as~~
30 ~~permitted or required by applicable State or federal statute or regulation or~~
31 ~~by third party contract. It is not the intent of this section to prohibit access to~~
32 ~~medical records by the treating physician except when the individual objects~~
33 ~~in writing. Records may also be disclosed without the written consent of the~~
34 ~~individual to agencies, institutions or individuals which are providing~~
35 ~~emergency medical services to the individual. Disclosure of information~~
36 ~~shall be limited to that which is necessary to meet the emergency law.~~
- 37 (7) To receive a reasonable response to his or her requests from the facility
38 administrator and staff.
- 39 (8) To associate and communicate privately and without restriction with people
40 and groups of his or her own choice on his or her own or their initiative at
41 any reasonable hour.
- 42 (9) To have access at any reasonable hour to a telephone where he or she may
43 speak privately.
- 44 (10) To send and receive mail promptly and unopened, unless the resident
45 requests that someone open and read mail, and to have access at his or her
46 expense to writing instruments, stationery, and postage.
- 47 (11) To be encouraged to exercise his or her rights as a resident and citizen, and
48 to be permitted to make complaints and suggestions without fear of coercion
49 or retaliation.
- 50 (12) To have and use his or her own possessions where reasonable and have an
51 accessible, lockable space provided for security of personal valuables. This

- 1 space shall be accessible only to the resident, the administrator, or
2 supervisor-in-charge.
- 3 (13) To manage his or her personal needs funds unless such authority has been
4 delegated to another. If authority to manage personal needs funds has been
5 delegated to the facility, the resident has the right to examine the account at
6 any time.
- 7 (14) To be notified when the facility is issued a provisional license or notice of
8 revocation of license by the North Carolina Department of Health and
9 Human Services and the basis on which the provisional license or notice of
10 revocation of license was issued. The resident's responsible family member
11 or guardian shall also be notified.
- 12 (15) To have freedom to participate by choice in accessible community activities
13 and in social, political, medical, and religious resources and to have freedom
14 to refuse such participation.
- 15 (16) To receive upon admission to the facility a copy of this section.
- 16 (17) To not be transferred or discharged from a facility except for medical
17 reasons, the residents' own or other residents' welfare, nonpayment for the
18 stay, or when the transfer is mandated under State or federal law. The
19 resident shall be given at least 30 days' advance notice to ensure orderly
20 transfer or discharge, except in the case of jeopardy to the health or safety of
21 the resident or others in the home. The resident has the right to appeal a
22 facility's attempt to transfer or discharge the resident pursuant to rules
23 adopted by the Medical Care Commission, and the resident shall be allowed
24 to remain in the facility until resolution of the appeal unless otherwise
25 provided by law. The Medical Care Commission shall adopt rules pertaining
26 to the transfer and discharge of residents that offer at least the same
27 protections to residents as State and federal rules and regulations governing
28 the transfer or discharge of residents from nursing homes."

29 **SECTION 6. G.S. 131E-144.3 reads as rewritten:**

30 **"§ 131E-144.3. Declaration of home care clients' rights.**

31 Each client of a home care agency shall have the following rights:

- 32 (1) To be informed and participate in his or her plan of care.
- 33 (2) To be treated with respect, consideration, dignity, and full recognition of his
34 or her individuality and right to privacy.
- 35 (3) To receive care and services that are adequate, appropriate, and in
36 compliance with relevant federal and State laws and rules and regulations.
- 37 (4) To voice grievances about care and not be subjected to discrimination or
38 reprisal for doing so.
- 39 (5) To have his or her personal and medical records kept confidential and not be
40 disclosed ~~without appropriate written consent except as permitted or~~
41 required by applicable State or federal law.
- 42 (6) To be free of mental and physical abuse, neglect, and exploitation.
- 43 (7) To receive a written statement of services provided by the agency and the
44 charges the client is liable for paying.
- 45 (8) To be informed of the process for acceptance and continuance of service and
46 eligibility determination.
- 47 (9) To accept or refuse services.
- 48 (10) To be informed of the agency's on-call service.
- 49 (11) To be informed of supervisory accessibility and availability.
- 50 (12) To be advised of the agency's procedures for discharge.
- 51 (13) To receive a reasonable response to his or her requests of the agency.

- 1 (14) To be notified within 10 days when the agency's license has been revoked,
2 suspended, canceled, annulled, withdrawn, recalled, or amended.
3 (15) To be advised of the agency's policies regarding patient responsibilities."
4 **SECTION 7.** This act becomes effective January 1, 2012.



SENATE BILL 607: Conform Medical Record Laws

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Stein
Analysis of: PCS to First Edition
S607-CSSQ-17

Date: April 26, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *Senate Bill 607 amends multiple statutes pertaining to the use and disclosure of an individual's "protected health information".*

CURRENT LAW: *The Privacy rule of HIPAA governs the use of certain health information (protected health information) by certain providers (covered entities/business associates). While the general rule prohibits disclosure without patient consent/authorization, it does permit covered entities to use or disclose this information for purposes of treatment, payment, health care operations, and certain other purposes. North Carolina by statute has imposed further limits on the disclosure of certain protected health information requiring a patient's affirmative consent prior to disclosure even for purposes allowed by HIPAA.*

BILL ANALYSIS:

Section 1 amends the Pharmacy Practice Act to authorize persons in custody of or having access to prescription orders (written and electronic) to divulge the contents or provide a copy to "a HIPAA covered entity" or health care provider who is not considered a covered entity for the purposes of (i) treatment, (ii) payment, (iii) or health care operations to the extent permitted or required under State and federal law.

Section 2 amends an exception provision to the general rule that governs the use of information relating to an individual served by a Chapter 122C regulated facility (confidential information shall not be disclosed without patient consent) by allowing any facility to share confidential information when necessary to provide appropriate and effective care, treatment, or habilitation of the client.

A facility as used in Chapter 122C is any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers.

The section further amends the exception provision relating to disclosures between CCNC (or other primary care case management program) and health care providers or entities that receive information from CCNC by authorizing those entities to disclose confidential information when necessary to conduct quality assessment and improvement or to provide appropriate and effective care, treatment, or habilitation of the client.

Finally the section places a limitation on disclosure between health care providers that are covered entities by requiring that prior to disclosure, the facility shall inform the client that the facility may make such disclosures unless the client objects in writing.

Section 3 amends Public Health laws relating to the disclosure of privileged patient medical information by including "research" as permitted under HIPAA as an appropriate disclosure.

Section 4 amends Public Health laws relating to the disclosure of information and records that identify a person who has a disease or condition that by State law must be reported. Specifically it authorizes the release for the purposes of treatment, payment, research, or health care operations to the extent the disclosure is permitted under HIPAA.

Senate PCS 607

Page 2

Sections 5 and 6 amend the Adult Care Home resident's and Home Care Service recipient's declaration of certain rights by authorizing the disclosure of personal and medical records as permitted or required under State or federal law and removing a prior written consent requirement.

EFFECTIVE DATE: This act becomes effective January 1, 2012.

HIPAA Basics¹

I. "Covered Entities" The rule applies to any health plan, health care clearinghouse, or health care provider who transmit health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards.

Health Plans. Individual and group plans that provide or pay the cost of medical care are covered entities. Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations ("HMOs"), Medicare, Medicaid, Medicare+Choice and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include employer-sponsored group health plans, government and church-sponsored health plans, and multi-employer health plans. There are exceptions—a group health plan with less than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity. Two types of government-funded programs are not health plans: (1) those whose principal purpose is not providing or paying the cost of health care, such as the food stamps program; and (2) those programs whose principal activity is directly providing health care, such as a community health center, or the making of grants to fund the direct provision of health care. Certain types of insurance entities are also not health plans, including entities providing only workers' compensation, automobile insurance, and property and casualty insurance. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity with respect to the health plan line of business.

Health Care Providers. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Rule. Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all "providers of services" (e.g., institutional providers such as hospitals) and "providers of medical or health services" (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Health Care Clearinghouses. *Health care clearinghouses* are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa. In most instances, health care clearinghouses will receive individually identifiable health information only when they are providing these processing services to a health plan or health care provider as a business associate. In such instances, only certain provisions of the Privacy Rule are

¹ <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html>

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applicable to the health care clearinghouse's uses and disclosures of protected health information. Health care clearinghouses include billing services, repricing companies, community health management information systems, and value-added networks if these entities perform clearinghouse functions.

II. Protected Health Information- The Privacy Rule protects all "*individually identifiable health information*" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

III. Permitted Use and Disclosure- A covered entity is permitted to use and disclose protected health information, without an individual's authorization for the following purposes or situations:

(1) To the Individual; (2) Treatment, Payment, and Health Care Operations; (3) When Given an Opportunity to Agree or Object; (4) Incident to otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; (6) Limited Data Set for the purposes of research, public health, or health care operations.

IV. Penalties and Enforcement-Civil Money Penalties. Office of Civil Rights within HHS may impose a penalty on a covered entity for a failure to comply with a requirement of the Privacy Rule. Penalties will vary significantly depending on factors such as the date of the violation, whether the covered entity knew or should have known of the failure to comply, or whether the covered entity's failure to comply was due to willful neglect. Penalties may not exceed a calendar year cap for multiple violations of the same requirement.

	For violations occurring prior to 2/18/2009	For violations occurring on or after 2/18/2009
Penalty Amount	Up to \$100 per violation	\$100 to \$50,000 or more per violation
Calendar Year Cap	\$25,000	\$1,500,000

In addition, OCR may choose to reduce a penalty if the failure to comply was due to reasonable cause and the penalty would be excessive given the nature and extent of the noncompliance.

Criminal Penalties. A person who knowingly obtains or discloses individually identifiable health information in violation of the Privacy Rule may face a criminal penalty of up to \$50,000 and up to one-year imprisonment. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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SENATE BILL 607*

Short Title: Conform Medical Record Laws.

(Public)

Sponsors: Senator Stein.

Referred to: Health Care.

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO CONFORM MEDICAL RECORD CONFIDENTIALITY LAWS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.36 reads as rewritten:

"§ 90-85.36. Availability of pharmacy records.

(a) Except as provided in subsections (b) and (c) below, written or electronic prescription orders on file in a pharmacy or other place where prescriptions are dispensed are not public records and any person having custody of or access to the prescription orders may divulge the contents or provide a copy only to the following persons:

- (1) An adult patient for whom the prescription was issued or a person who is legally appointed guardian of that person;
- (2) An emancipated minor patient for whom the prescription order was issued or a person who is the legally appointed guardian of that patient;
- (3) An unemancipated minor patient for whom the prescription order was issued when the minor's consent is sufficient to authorize treatment of the condition for which the prescription was issued;
- (4) A parent or person in loco parentis of an unemancipated minor patient for whom the prescription order was issued when the minor's consent is not sufficient to authorize treatment for the condition for which the prescription is issued;
- (5) The licensed practitioner who issued the prescription;
- (6) The licensed practitioner who is treating the patient for whom the prescription was issued;
- (7) A pharmacist who is providing pharmacy services to the patient for whom the prescription was issued;
- (8) Anyone who presents a written authorization for the release of pharmacy information signed by the patient or his legal representative;
- (9) Any person authorized by subpoena, court order or statute;
- (10) Any firm, association, partnership, business trust, corporation or company charged by law or by contract with the responsibility of providing for or paying for medical care for the patient for whom the prescription order was issued;
- (11) A member or designated employee of the Board;
- (12) The executor, administrator or spouse of a deceased patient for whom the prescription order was issued;



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(13) Researchers and surveyors who have approval from the Board. The Board shall issue this approval when it determines that there are adequate safeguards to protect the confidentiality of the information contained in the prescription orders and that the researchers or surveyors will not publicly disclose any information that identifies any person; or

(14) The person owning the pharmacy or his authorized agent; or

(15) A HIPAA covered entity or a health care provider who is not a covered entity for purposes of treatment, payment, or health care operations to the extent that disclosure is permitted or required by applicable State or federal law.

(b) A pharmacist may disclose any information to any person only when he reasonably determines that the disclosure is necessary to protect the life or health of any person.

(c) Records required to be kept by G.S. 90-93(d) (Schedule V) are not public records and shall be disclosed at the pharmacist's discretion."

SECTION 2. G.S. 122C-55 reads as rewritten:

"§ 122C-55. Exceptions; care and treatment.

(a) ~~Any area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ may share confidential information regarding any client of that facility with any other ~~area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. For the purposes of this subsection, coordinate means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services by one or more facilities and includes the referral of a client from one facility to another.

(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~~subsection, subsection (a6), and subsection (a6)(a7) 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.

(a2) Any area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with any other area facility or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill when necessary to conduct payment activities relating to an individual served by the facility. Payment activities are activities undertaken by a facility to obtain or provide reimbursement for the provision of services and may include, but are not limited to, determinations of eligibility or coverage, coordination of benefits, determinations of cost-sharing amounts, claims management, claims processing, claims adjudication, claims appeals, billing and collection activities, medical necessity reviews, utilization management and review, precertification and preauthorization of services, concurrent and retrospective review of services, and appeals related to utilization management and review.

(a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any State or area facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

(a4) An area authority or county program may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or county program, when the area authority or county program determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or county program's network of qualified providers as provided in G.S. 122C-115.2(b)(1) b., G.S. 122C-141(a), the State Plan, and rules of the Secretary. For the purposes of this subsection, the purposes or activities for which confidential information may be disclosed include, but are not limited to, quality assessment and improvement activities, provider accreditation and staff credentialing, developing contracts and negotiating rates, investigating and responding to client grievances and complaints, evaluating practitioner and provider performance, auditing functions, on-site monitoring, conducting consumer satisfaction studies, and collecting and analyzing performance data.

(a5) Any area facility may share confidential information with any other area facility regarding an applicant when necessary to determine whether the applicant is eligible for area facility services. For the purpose of this subsection, the term "applicant" means an individual who contacts an area facility for services.

(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~~ the Department's Community Care of North Carolina Program, or other primary care case management program, 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 the 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~~ when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment, or habilitation of the client.

(a7) A facility may share confidential information with one or more health care providers that are covered entities for the same purposes set forth in subsection (a1) of this section. Before making disclosures under this subsection, the facility shall inform the client that the facility may make such disclosures unless the client objects in writing. If the client objects in writing, the disclosures otherwise permitted by this subsection are prohibited. A covered entity receiving confidential information from a facility under this subsection may use and disclose the information when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment, or habilitation of the client. For the purposes of this subsection, the terms 'covered entity' and 'health care provider' have the meaning given those terms in 45 Code of Federal Regulations § 160.103.

...."

SECTION 3. G.S. 130A-12 reads as rewritten:**"§ 130A-12. Confidentiality of records.**

All records containing privileged patient medical information, information protected under 45 Code of Federal Regulations Parts 160 and 164, and information collected under the authority of Part 4 of Article 5 of this Chapter that are in the possession of the Department of Health and Human Services, the Department of Environment and Natural Resources, or local health departments shall be confidential and shall not be public records pursuant to G.S. 132-1. Information contained in the records may be disclosed only when disclosure is authorized or required by State or federal law. Notwithstanding ~~G.S. 8-53 or G.S. 130A-143, G.S. 8-53,~~ the information contained in the records may be disclosed for purposes of treatment, payment, research, or health care operations to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i). For purposes of this section, the terms "treatment," "payment," "research," and "health care operations" have the meanings given those terms in 45 Code of Federal Regulations § 164.501."

SECTION 4. G.S. 130A-143 reads as rewritten:**"§ 130A-143. Confidentiality of records.**

All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. This information shall not be released or made public except under the following circumstances:

- (1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified;
- (2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardian;
- (3) Release is made ~~to health care personnel providing medical care to the patient;~~ for purposes of treatment, payment, research, or health care operations to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i). For purposes of this section, the terms 'treatment,' 'payment,' 'research' and 'health care operations' have the meaning given those terms in 45 Code of Federal Regulations § 164.501;
- (4) Release is necessary to protect the public health and is made as provided by the Commission in its rules regarding control measures for communicable diseases and conditions;
- (5) Release is made pursuant to other provisions of this Article;
- (6) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties and those engaged in the trial of the case;
- (7) Release is made by the Department or a local health department to a court or a law enforcement official for the purpose of enforcing this Article or Article 22 of this Chapter, or investigating a terrorist incident using nuclear, biological, or chemical agents. A law enforcement official who receives the information shall not disclose it further, except (i) when necessary to enforce this Article or Article 22 of this Chapter, or when necessary to conduct an investigation of a terrorist incident using nuclear, biological, or chemical agents, or (ii) when the Department or a local health department seeks the assistance of the law enforcement official in preventing or controlling the spread of the disease or condition and expressly authorizes the disclosure as necessary for that purpose;

- (8) Release is made by the Department or a local health department to another federal, state or local public health agency for the purpose of preventing or controlling the spread of a communicable disease or communicable condition;
- (9) Release is made by the Department for bona fide research purposes. The Commission shall adopt rules providing for the use of the information for research purposes;
- (10) Release is made pursuant to G.S. 130A-144(b); or
- (11) Release is made pursuant to any other provisions of law that specifically authorize or require the release of information or records related to AIDS."

SECTION 5. G.S. 131D-21 reads as rewritten:

"§ 131D-21. Declaration of residents' rights.

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

- (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
- (2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
- (3) To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services.
- (4) To be free of mental and physical abuse, neglect, and exploitation.
- (5) Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need.
- (6) To have his or her personal and medical records kept confidential and not disclosed ~~without the written consent of the individual or guardian, which consent shall specify to whom the disclosure may be made, except as permitted or required by applicable State or federal statute or regulation or by third party contract. It is not the intent of this section to prohibit access to medical records by the treating physician except when the individual objects in writing. Records may also be disclosed without the written consent of the individual to agencies, institutions or individuals which are providing emergency medical services to the individual. Disclosure of information shall be limited to that which is necessary to meet the emergency law.~~
- (7) To receive a reasonable response to his or her requests from the facility administrator and staff.
- (8) To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
- (9) To have access at any reasonable hour to a telephone where he or she may speak privately.
- (10) To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationery, and postage.
- (11) To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation.
- (12) To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge.

- (13) To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time.
- (14) To be notified when the facility is issued a provisional license or notice of revocation of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian shall also be notified.
- (15) To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation.
- (16) To receive upon admission to the facility a copy of this section.
- (17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

SECTION 6. G.S. 131E-144.3 reads as rewritten:

"§ 131E-144.3. Declaration of home care clients' rights.

Each client of a home care agency shall have the following rights:

- (1) To be informed and participate in his or her plan of care.
- (2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
- (3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
- (4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.
- (5) To have his or her personal and medical records kept confidential and not be disclosed ~~without appropriate written consent except as permitted or required by applicable State or federal law.~~
- (6) To be free of mental and physical abuse, neglect, and exploitation.
- (7) To receive a written statement of services provided by the agency and the charges the client is liable for paying.
- (8) To be informed of the process for acceptance and continuance of service and eligibility determination.
- (9) To accept or refuse services.
- (10) To be informed of the agency's on-call service.
- (11) To be informed of supervisory accessibility and availability.
- (12) To be advised of the agency's procedures for discharge.
- (13) To receive a reasonable response to his or her requests of the agency.
- (14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.

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(15) To be advised of the agency's policies regarding patient responsibilities."

SECTION 7. This act becomes effective January 1, 2012.

VISITOR REGISTRATION SHEET

Committee on Health Care

4/27/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Steve Shore

NC Pediatric Soc,

Annaliese Dolph

DR NC

Dick Carter



DAVE SIMP

CAOC

Kristi Huff

NCHCFA

Betsy Vetter

Amer Heart Assn

John C. Lafferty

American Heart Assoc.

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NC BRAIN INJURY ADVISORY COUNCIL

Jack Graham

GSK

Garry Stuchman

GSK

VISITOR REGISTRATION SHEET

Committee on Health Care

4/27/11

Name of Committee

Date

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NAME	FIRM OR AGENCY AND ADDRESS
Rob Lamm	PLA
HUGH TILSON	NCHH
Dana Simpson	Smith Anderson
Jon Carr	NC Pediatric Society
Tom V. V. V.	ASC
Freddie Zurett	Smith Anderson / N3CN
Clifford Douthett	Dr. Ingold
SCOTT SLITKIN	SELF
Rose Williams	NC DOI
Kyle Cutler	AKEE
Matt Wolfe	Parker Poe

NAME	COMPANY
Michele Erickson	Greensboro Orthopaedics
Dr. A. Geoffrey MD	Greensboro Orthopaedics
Kevin Supple M.D.	//
RICHARD RAMOS, MD	"
Bill Gramig MD	"
Frank Alaisio, MD	//
Julian Bobbitt	Smith Anderson, attorneys

VISITOR REGISTRATION SHEET

Committee on Health Care

Name of Committee

4/27/11

Date

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CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Eckel	NC Assoc Pharmacists
Sara Dixon	NC Assoc Pharmacists
Mark Botts	UNC School of Government
Joe Guarino	AHC SM, Peoria, IL
Tami Fitzgerald	AHC SM
TINA GORDON	NC Nurses
Elizabeth	NAMI NC
Kay Paksey	NASW-NC
Janet Ann	NCNA NDN
Angie Ell	NLRMA
Gracie Kelly	FirstHealth
Angie Harris	WM

VISITOR REGISTRATION SHEET

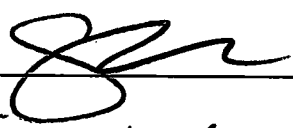
Committee on Health Care

4/27/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DANIEL BAUM	TRATMAN SANDERS
STEVE MITCHELL	ASTELLAS
Peter M. Zym	
Brian Forrest MD	NC Academy of Family Physicians
Chris Bygott	NCMS
John Mangum, MD	NCMS
N. Shuill	NCMS
Morgan Norris	NCAP
MACARY MARCINIAK	NCAP
Jay Campbell	NC Board of Pharmacy
Guelyn Hawthorne	EHGR

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, May 4, 2011

Room 544, LOB

The Senate Committee on Health Care met at 11:00 a.m. on Wednesday, May 4, 2011, in Room 544 of the Legislative Office Building. Fourteen members were present, with Senator Harris Blake presiding.

Senator Blake called the meeting to order, welcomed everyone and introduced the Sergeants-at-Arms and Pages assisting with the meeting. At this time, Senator Blake announced that S.B.743 and SB 246 had been pulled.

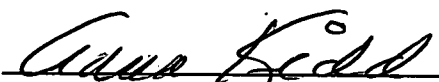
Senator Blake recognized Senator Stan Bingham to explain SB 354; "Rental Property/Lithium Battery Smoke Alarms." After Senator Bingham completed his explanation of the bill, Senator Blake asked if anyone from the audience wished to make comments. Several interested parties took the podium and stated their case (see attachments). After everyone had stated their concerns and comments, Senator Blake asked for motions. Senator Purcell made a motion for a favorable report as amended. Following the amendment, more questions were asked and answered. The bill was reported Unfavorable as to Bill, But favorable as to Committee Substitute Bill.

At this point, Senator Blake introduced Senator Eric Mansfield to explain SB 718, "Prescription Integrity Act". Senator Purcell moved to accept the PCS There was more discussion, questions and answers. Senator Blake asked if anyone wanted to speak on SB 718. Mr. Mike James (pharmacist) and Mr. Jay Campbell (Board of Pharmacists) both spoke on the bill. The Committee unanimously decided to postpone this bill.

Senator Blake adjourned the meeting at 11:55 a.m.



Senator Harris Blake, Co-Chair



Anna Kidd, Committee Assistant

Anna Kidd (Sen. Blake)

From: Maria Kinnaird (Sen. Bingham)
at: Thursday, April 28, 2011 8:45 AM
cc: Sen. Thom Goolsby; Sen. David Rouzer; Sen. Fletcher Hartsell, Jr.; Sen. Eric Mansfield
Morgan Beam (Sen. Goolsby); Judy Edwards (Sen. Rouzer); Gerry Johnson (Sen. Hartsell);
Jackie Ray (Sen. Mansfield)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wed, 05-04-2011 at 11:00 AM

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 4, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 354	Rental Property/Lithium Battery Smoke Alarms.	Senator Bingham
SB 743	Encourage Volunteer Health Care Providers.	Senator Goolsby
SB 644	DSS Adoption Assistance Agreements Binding.	Senator Rouzer
SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell
SB 718	Prescription Integrity Act.	Senator Mansfield

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee
Wednesday, May 4, 2011, 11:00 A.M.
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction

Bills

SB 354	Rental Property/Lithium Battery Smoke Alarm	Senator Bingham
SB 743	Encourage Volunteer Health Care Providers	Senator Goolsby
SB 644	DSS Adoption Assistance Agreements Binding	Senator Rouzer
SB 0246	Expand Pharmacists' Immunizing Authority	Senator Hartsell
SB 718	Prescription Integrity Act	Senator Mansfield

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, May 04, 2011

Senator BLAKE,

submits the following with recommendations as to passage:

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

S.B.	354	Rental Property/Lithium Battery Smoke Alarms.
		Draft Number: PCS 55298
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2011

S

1

SENATE BILL 354

Short Title: Rental Property/Lithium Battery Smoke Alarms.

(Public)

Sponsors: Senators Bingham; Forrester, Hartsell, Rabon, and Stevens.

Referred to: Rules and Operations of the Senate.

March 17, 2011

A BILL TO BE ENTITLED

AN ACT PROVIDING THAT AFTER DECEMBER 31, 2011, LANDLORDS SHALL, WHEN INSTALLING A NEW SMOKE ALARM OR REPLACING AN EXISTING SMOKE ALARM, INSTALL A TEN-YEAR LITHIUM BATTERY SMOKE ALARM EXCEPT IN CERTAIN CASES, AND PROVIDING THAT LANDLORDS MAY DEDUCT FROM THE TENANT SECURITY DEPOSIT DAMAGE TO A SMOKE ALARM OR CARBON MONOXIDE ALARM, AS RECOMMENDED BY THE NORTH CAROLINA CHILD FATALITY TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 42-42 reads as rewritten:

"§ 42-42. Landlord to provide fit premises.

(a) The landlord shall:

...

(5) Provide operable smoke ~~detectors,~~alarms, either battery-operated or electrical, having an Underwriters' Laboratories, Inc., listing or other equivalent national testing laboratory approval, and install the smoke ~~detectors,~~alarms in accordance with either the standards of the National Fire Protection Association or the minimum protection designated in the manufacturer's instructions, which the landlord shall retain or provide as proof of compliance. The landlord shall replace or repair the smoke ~~detectors~~alarms within 15 days of receipt of notification if the landlord is notified of needed replacement or repairs in writing by the tenant. The landlord shall ensure that a smoke ~~detector-~~alarm is operable and in good repair at the beginning of each tenancy. Unless the landlord and the tenant have a written agreement to the contrary, the landlord shall place new batteries in a battery-operated smoke ~~detector-~~alarm at the beginning of a tenancy and the tenant shall replace the batteries as needed during the ~~tenancy-~~tenancy, except where the smoke alarm is a 10-year lithium battery smoke alarm as required by subdivision (5a) of this subsection. Failure of the tenant to replace the batteries as needed shall not be considered as negligence on the part of the tenant or the landlord.

(5a) After December 31, 2011, when installing a new smoke alarm or replacing an existing smoke alarm, install a 10-year lithium battery smoke alarm. However, the landlord shall not be required to install a 10-year lithium battery smoke alarm as required by this subdivision in either of the following circumstances:



* 5 3 5 4 - V - 1 *

- 1 a. The dwelling unit is equipped with a hardwired smoke alarm with a
2 battery backup.
3 b. The dwelling unit is equipped with a smoke alarm combined with a
4 carbon monoxide alarm that meets the requirements provided in
5 subdivision (7) of this section.
6

7 ...
8 (7) Provide a minimum of one operable carbon monoxide ~~detector~~-alarm per
9 rental unit per level, either battery-operated or electrical, that is listed by a
10 nationally recognized testing laboratory that is OSHA-approved to test and
11 certify to American National Standards Institute/Underwriters Laboratories
12 Standards ANSI/UL2034 or ANSI/UL2075, and install the carbon monoxide
13 ~~detectors~~-alarms in accordance with either the standards of the National Fire
14 Protection Association or the minimum protection designated in the
15 manufacturer's instructions, which the landlord shall retain or provide as
16 proof of compliance. A landlord that installs one carbon monoxide ~~detector~~
17 alarm per rental unit per level shall be deemed to be in compliance with
18 standards under this subdivision covering the location and number of
19 ~~detectors~~-alarms. The landlord shall replace or repair the carbon monoxide
20 ~~detectors~~-alarms within 15 days of receipt of notification if the landlord is
21 notified of needed replacement or repairs in writing by the tenant. The
22 landlord shall ensure that a carbon monoxide ~~detector~~-alarm is operable and
23 in good repair at the beginning of each tenancy. Unless the landlord and the
24 tenant have a written agreement to the contrary, the landlord shall place new
25 batteries in a battery-operated carbon monoxide ~~detector~~-alarm at the
26 beginning of a tenancy, and the tenant shall replace the batteries as needed
27 during the tenancy. Failure of the tenant to replace the batteries as needed
28 shall not be considered as negligence on the part of the tenant or the
29 landlord. A carbon monoxide ~~detector~~-alarm may be combined with smoke
30 ~~detectors~~-alarms if the combined ~~detector~~-alarm does both of the following:
31 (i) complies with ANSI/UL2034 or ANSI/UL2075 for carbon monoxide
32 alarms and ANSI/UL217 for smoke ~~detectors~~-alarms; and (ii) emits an alarm
33 in a manner that clearly differentiates between detecting the presence of
34 carbon monoxide and the presence of smoke. This subdivision applies only
35 to dwelling units having a fossil-fuel burning heater, appliance, or fireplace,
36 and in any dwelling unit having an attached garage. Any operable carbon
37 monoxide detector installed before January 1, 2010, shall be deemed to be in
38 compliance with this subdivision.

38 "

39 SECTION 2. G.S. 42-43 reads as rewritten:

40 "§ 42-43. Tenant to maintain dwelling unit.

41 (a) The tenant shall:

42 ...
43 (4) Not deliberately or negligently destroy, deface, damage, or remove any part
44 of the premises, nor render inoperable the smoke ~~detector~~-alarm or carbon
45 monoxide ~~detector~~-alarm provided by the landlord, or knowingly permit any
46 person to do so.

47 ...
48 (7) Notify the landlord, in writing, of the need for replacement of or repairs to a
49 smoke ~~detector~~-alarm or carbon monoxide ~~detector~~-alarm. The landlord shall
50 ensure that a smoke ~~detector~~-alarm and carbon monoxide ~~detector~~-alarm are
51 operable and in good repair at the beginning of each tenancy. Unless the

landlord and the tenant have a written agreement to the contrary, the landlord shall place new batteries in a battery-operated smoke ~~detector~~alarm and battery-operated carbon monoxide ~~detector~~alarm at the beginning of a tenancy and the tenant shall replace the batteries as needed during the ~~tenancy~~tenancy, except where the smoke alarm is a 10-year lithium battery smoke alarm as required by G.S. 42-42(a)(5a). Failure of the tenant to replace the batteries as needed shall not be considered as negligence on the part of the tenant or the landlord.

...."

SECTION 3. G.S. 42-44 reads as rewritten:

"§ 42-44. General remedies, penalties, and limitations.

...

(a1) If a landlord fails to provide, install, replace, or repair a smoke ~~detector~~alarm under the provisions of G.S. 42-42(a)(5) or a carbon monoxide ~~detector~~alarm under the provisions of G.S. 42-42(a)(7) within 30 days of having received written notice from the tenant or any agent of State or local government of the landlord's failure to do so, the landlord shall be responsible for an infraction and shall be subject to a fine of not more than two hundred fifty dollars (\$250.00) for each violation. After December 31, 2011, if the landlord installs a new smoke alarm or replaces an existing smoke alarm, the smoke alarm shall be a 10-year lithium battery smoke alarm, except as provided in G.S. 42-42(a)(5a). The landlord may temporarily disconnect a smoke ~~detector~~alarm or carbon monoxide ~~detector~~alarm in a dwelling unit or common area for construction or rehabilitation activities when such activities are likely to activate the smoke ~~detector~~alarm or carbon monoxide ~~detector~~alarm or make it inactive.

(a2) If a smoke ~~detector~~alarm or carbon monoxide ~~detector~~alarm is disabled or damaged, other than through actions of the landlord, the landlord's agents, or acts of God, the tenant shall reimburse the landlord the reasonable and actual cost for repairing or replacing the smoke ~~detector~~alarm or carbon monoxide ~~detector~~alarm within 30 days of having received written notice from the landlord or any agent of State or local government of the need for the tenant to make such reimbursement. If the tenant fails to make reimbursement within 30 days, the tenant shall be responsible for an infraction and subject to a fine of not more than one hundred dollars (\$100.00) for each violation. The tenant may temporarily disconnect a smoke ~~detector~~alarm or carbon monoxide ~~detector~~alarm in a dwelling unit to replace the batteries or when it has been inadvertently activated.

...."

SECTION 4. G.S. 42-51 reads as rewritten:

"§ 42-51. Permitted uses of the deposit.

Security deposits for residential dwelling units shall be permitted only for the tenant's possible nonpayment of rent and costs for water or sewer services provided pursuant to G.S. 62-110(g), damage to the premises, including the damage or destruction of a smoke or carbon monoxide alarm, nonfulfillment of rental period, any unpaid bills that become a lien against the demised property due to the tenant's occupancy, costs of re-renting the premises after breach by the tenant, costs of removal and storage of tenant's property after a summary ejectment proceeding or court costs in connection with terminating a tenancy. The security deposit shall not exceed an amount equal to two weeks' rent if a tenancy is week to week, one and one-half months' rent if a tenancy is month to month, and two months' rent for terms greater than month to month. These deposits must be fully accounted for by the landlord as set forth in G.S. 42-52."

SECTION 5. Sections 1 through 4 of this act become effective December 31, 2011. The remainder of this act is effective when it becomes law.



SENATE BILL 354: Rental Property/Lithium Battery Smoke Alarms

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: First Edition

Date: April 29, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 354 requires landlords to install a ten-year lithium battery smoke alarm when installing a new smoke alarm or replacing an existing smoke alarm, except under certain circumstances. Additionally, Senate Bill 354 specifically includes damage to or destruction of a smoke alarm or carbon monoxide alarm as a use for a tenant's security deposit.*

CURRENT LAW: Currently, the law requires landlords to install operable smoke detectors and place new batteries in the device at the beginning of tenancy. A tenant is not to destroy the smoke detector or render it inoperable. The tenant is responsible for replacing any batteries as needed on the smoke detector, unless there is an agreement to the contrary between the landlord and tenant. Failure of a landlord to provide a functional smoke detector is an infraction, carrying a fine of not more than \$250.

BILL ANALYSIS:

Section 1: Requires landlords to install a 10-year lithium battery smoke alarm when installing a new smoke alarm or replacing an existing smoke alarm. This requirement will take effect after December 31, 2011. The landlord will not be required to install a 10-year lithium battery smoke alarm under the following circumstances:

- The dwelling unit is equipped with a hardwired smoke alarm with battery backup
- The dwelling unit is equipped with a smoke alarm combined with a carbon monoxide alarm meeting specific requirements

Section 2: Provides a tenant is not required to replace smoke alarm batteries if their unit contains a 10-year lithium battery smoke alarm and makes conforming changes.

Section 3: Provides that, after December 31, 2011, if a landlord installs a new smoke alarm or replaces an existing smoke alarm, it must be replaced with a 10-year lithium battery smoke alarm.

Section 4: Specifically includes damage to or destruction of a smoke alarm or carbon monoxide alarm as a permitted use of a tenant's security deposit.

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

S354-SMTK-22(e1) v3



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 354

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

S354-ALM-45 [v.2]

Page 1 of 1

Comm. Sub. [NO]
Amends Title [YES]
First Edition

Date May 4, 2011

Senator Bingham

1 moves to amend the bill on page 1, line 4, by inserting after the word "A" and before "TEN-
2 YEAR" the phrase "TAMPER RESISTANT";

3
4 and on page 1, line 28 by inserting after the word "a" and before "10-year" the phrase "tamper
5 resistant";

6
7 and on page 1, line 33 and line 34, by inserting in both places after the word "a" and before
8 "10-year" the phrase "tamper resistant";

9
10 and on page 3, line 5, by inserting after the word "a" and before "10-year" the phrase "tamper
11 resistant";

12
13 and on page 3, line 19, by inserting after the word "a" and before "10-year" the phrase "tamper
14 resistant".

15
16
SIGNED

Stan Bingham
Amendment Sponsor

SIGNED

Harries Blake
Committee Chair if Senate Committee Amendment

ADOPTED

✓

FAILED

TABLED



* S 3 5 4 - A L M - 4 5 - V - 2 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 718

Short Title: Prescription Integrity Act.

(Public)

Sponsors: Senators Mansfield; and Pate.

Referred to: Health Care.

April 20, 2011

A BILL TO BE ENTITLED

AN ACT CLARIFYING UNDER WHAT CIRCUMSTANCES THE SUBSTITUTION OF
GENERIC PRESCRIPTION DRUGS IS ALLOWED UNDER THE PHARMACY
PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.27(1) reads as rewritten:

"§ 90-85.27. Definitions.

As used in G.S. 90-85.28 through G.S. 90-85.31:

- (1) "Equivalent drug product" means a drug product which has the same established name, active ingredient, strength, quantity, and dosage form, and which is listed as therapeutically equivalent to the drug product identified in the ~~prescription~~ prescription under the most recent version of the Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations."

SECTION 2. G.S. 90-85.28 is amended by adding a new subsection to read:

"(b2) A pharmacist may not substitute any drug product that is not an equivalent drug product identified on the prescription unless, before making the substitution, the pharmacist does each of the following:

- (1) Obtains and documents the prescriber's written or verbal consent.
- (2) Obtains and documents the patient's written or verbal consent, either directly or through an authorized representative.
- (3) Maintains documentation of prescriber and patient consent on file in accordance with the provisions of G.S. 90-85.26.

As used in this subsection, 'substitution' refers to the selection and dispensing of a drug product that is different from the drug product prescribed."

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



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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 718
PROPOSED COMMITTEE SUBSTITUTE S718-CSSH-13 [v.2]

4/26/2011 2:48:33 PM

Short Title: Prescription Integrity Act.

(Public)

Sponsors:

Referred to:

April 20, 2011

- 1 A BILL TO BE ENTITLED
2 AN ACT CLARIFYING UNDER WHAT CIRCUMSTANCES THE SUBSTITUTION OF
3 GENERIC PRESCRIPTION DRUGS IS ALLOWED UNDER THE PHARMACY
4 PRACTICE ACT.
5 The General Assembly of North Carolina enacts:
6 SECTION 1. G.S. 90-85.27(1) reads as rewritten:
7 "§ 90-85.27. Definitions.
8 As used in G.S. 90-85.28 through G.S. 90-85.31:
9 (1) "Equivalent drug product" means a drug product which has the same
10 established name, active ingredient, strength, quantity, and dosage form, and
11 which is listed as therapeutically equivalent to the drug product identified in
12 the ~~prescription~~ prescription under the most recent version of the Food and
13 Drug Administration's Approved Drug Products with Therapeutic
14 Equivalence Evaluations".
15 SECTION 2. G.S. 90-85.28 is amended by adding a new subsection to read:
16 "(b2) A pharmacist may not substitute any drug product that is not an equivalent drug
17 product identified on the prescription unless, before making the substitution, the pharmacist
18 does each of the following:
19 (1) Obtains and documents the prescriber's written or verbal consent.
20 (2) Obtains and documents the patient's written or verbal consent, either directly
21 or through an authorized representative.
22 (3) Maintains documentation of prescriber and patient consent on file in
23 accordance with the provisions of G.S. 90-85.26."
24 SECTION 3. This act becomes effective January 1, 2012.



* S 7 1 8 - C S S H - 1 3 - V - 2 *



SENATE BILL 718: Prescription Integrity Act

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Mansfield
Analysis of: PCS to First Edition
S718-CSSH-13

Date: April 26, 2011
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *Senate Bill 718 amends the definition of an equivalent drug product and requires a pharmacist to obtain and document the consent of the prescriber and the patient before substituting a drug that is not an equivalent drug product. (The Proposed Committee Substitute removes language in the original bill and changes the effective date.)*

CURRENT LAW: "Equivalent drug product" is currently defined (§90-85.27(1)) as a drug product which has the same established name, active ingredient, strength, quantity, and dosage form, and which is therapeutically equivalent to the drug product identified in the prescription. This definition applies to the use of this term in statutory sections with the following headings: Selection by pharmacists permissible; prescriber may permit or prohibit selection; price limit on selected drugs (§90-85.28); Prescription label (§90-85.29); Prescription record (§90-85.30); and Prescriber and pharmacist liability not extended (§90-85.31).

G.S. 90-85.26 pertains to the preservation of prescription orders. It requires every pharmacist-manager to maintain for at least three years the original of every prescription order and refill compounded or dispensed at the pharmacy except for prescription orders recorded in a patient's medical record. This section of the law also requires every pharmacy permittee's designated agent to maintain documentation of alleged medication errors and incidents described in G.S. 90-85.47(e)(1) for which the pharmacy permittee has knowledge.

BILL ANALYSIS: Section 1 of Senate Bill 718 amends the definition in G.S. 90-85.27 to provide that an "equivalent drug product" is:

- a drug product which has the same established name, active ingredient, strength, quantity, and dosage form, and
- listed as therapeutically equivalent to the drug product identified in the prescription under the most recent version of the Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations.

Section 2 of the Bill amends G.S. 90-85.28 to prohibit a pharmacist from substituting any drug that is not an equivalent drug product unless the pharmacist does all of following prior to making the substitution:

1. Obtains and documents the prescriber's written or verbal consent.
2. Obtains and documents the patient's written or verbal consent, either directly or through an authorized representative.
3. Maintains documentation of prescriber and patient consent on file in accordance with the requirements pertaining to the preservation of prescription orders (G.S. 90-85.26).

EFFECTIVE DATE: Senate Bill 718 would become January 1, 2012.

BACKGROUND: *Approved Drug Products with Therapeutic Equivalence Evaluations* (Orange Book) is provided by the Food and Drug Administration.

S718-SMSH-58(CSSH-13) v2

PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 5-31 TIME: 11 AM

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!!

Page	Name	Hometown	Sponsoring Senator
1	~~IGa Bailey~~ Igā Bailey	Raleigh	Blue
2	Katie Brown	Fayetteville	Meredith
	Courtney Collier	Deep Run	Jackson
4			
5			
6			
7			
8			
9			
10			

Do not add names below the grid.

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

VISITOR REGISTRATION SHEET

Health Care
Name of Committee

May 4, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
<u>Julia Adams</u>	<u>The Arc of NC</u>
<u>Ken Melton</u>	<u>K.M.A.</u>
<u>Barbara Condu</u>	<u>BKCR</u>
<u>John McMullen</u>	<u>MFSS</u>
<u>Evelyn Hawthorne</u>	<u>EHGR</u>
<u>Jay Condit</u>	<u>NCBOP</u>
<u>Randall Best</u>	<u>DM A</u>
<u>Paul O'Brien</u>	<u>PFFDNC</u>
<u>Lisa Hanzjan</u>	<u>NCAAN</u>
<u>Greg Flynn</u>	<u>gregflynn.org</u>
<u>Elizabeth Haly</u>	<u>CF TF</u>

VISITOR REGISTRATION SHEET

Senate Committee on Education/Higher Education
Name of Committee

May 4, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Charles Peller

UNCG SA

~~Jeanne Feenick~~ UNC

Jay Schalin

Pope Center

Christopher Hill

NC Justice Center

Chris Agan

DOA

Barbara Conner

Beck

Anne Bander

DOA

Susan McCracken

Appalachian State University

Tom Cors

TNC

John Broudo

WCCU

Deborah Bonds

WCCU

Health Care
Name of Committee

May 4, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

FIRM OR AGENCY AND ADDRESS[illegible]

VISITOR REGISTRATION SHEET

Health Care
Name of Committee

5-4-11
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elizabeth Suttles	
Bill Ruck	AZP
Mil Jones	AZP
Chris Harn	NCAH
Tim Harn	Th Harn
Thom Mansfield	NCMB
Jan Parker	NC Sose kids
Kelly Ransdell	NCDOH/ OstFm - SafeKids NC
Sherris Troop	Get Alarmed, NC/ NC DHHS Div. of Pub. Health
Doug Hearn	Williams Menden
Mattie Ann McConnell	Couchies Healthcare Svc
Jan Carr	Jordan Bick

VISITOR REGISTRATION SHEET

Healed Care

Name of Committee

5-4-11

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
BJ Miller	MOSES CONE
Christine Gray	Wake Med
John Chappell	Am. Heart Assoc.
W. Gordon Phipps	DIC & Assoc.
Mari Wilde	Novant
Daniel Baum	TROUTMAN SANDERS
Sam Slobbin	JSS
Steve Widdell	Atellas
Krist Huff	NCHCFA

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, May 11, 2011

Room 544, LOB

The Senate Committee on Health Care met at 11:00 a.m. on Wednesday, May 22, 2011, in Room 544 of the Legislative Office Building. Thirteen (13) members were present; Senator Louis Pate presided.

Senator Pate called the meeting to order, welcomed everyone and introduced the Sergeants-at-Arms: Chester White, Bob Myrick and Donna Blake. He then introduced the Pages assisting with the meeting: Alexis McDonald from Raleigh and Jessica Williford of Fuquay Varina, both sponsored by Senator Phil Berger.

The following bills were brought before the Committee for consideration:

SB 512, "Adult Day Care/Overnight Respite Program" was brought before the Committee with a PCS; Senator Atwater made a motion for the PCS to be considered; motion carried. Senator Clary was recognized to explain the bill. After questions had been answered, Senator Forrester made a motion for a favorable report, unfavorable to the original bill; and the motion was carried.

HB 474, "Protect Adult Care Home Residents" also was brought before the Committee with a PCS, and was explained by Representative Weiss. Senator Atwater made a motion that the PCS be considered; motion carried. After a few questions, Senator Purcell made a motion that the bill receive a favorable report, unfavorable to the original bill; the motion carried.

SB 471, "Youth Skin Cancer Prevention Act" was the next bill brought before the Committee with a PCS. Senator Tucker made a motion for the PCS to be considered; Senator Forrester explained the bill. After much discussion, both from members and visitors, Senator Purcell moved for a favorable report, unfavorable to the original bill, and recommended for referral to the Commerce Committee. The motion carried.

SB 644, "DSS Adoption Assistance Agreements Binding" also came with a PCS. Senator Forrester made a motion for the PCS to be adopted for discussion; Senator Bingham explained the bill. Senator Meredith moved for a favorable report with unfavorable to the original bill; motion carried.

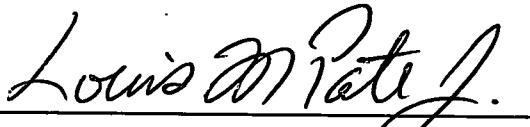
Health Care Committee

May 11, 2011

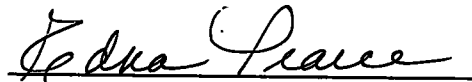
Page 2

SB 670, "Revise Membership/Hearing Aid Fitters Board" came before the Committee with a PCS. Senator Berger moved for the PCS to be adopted for discussion. Senator Hartsell explained the bill. After allowing time for questions, Senator Bingham moved for a favorable report to the PCS with unfavorable as to the original bill, and recommended referral to the Finance Committee.

Senator Pate adjourned the meeting at 11:55 a.m.



Senator Louis M. Pate, Jr., Chair



Edna Pearce, Committee Clerk

Edna Pearce (Sen. Pate)

From: Maria Kinnaird (Sen. Bingham)
it: Tuesday, May 10, 2011 5:16 PM
Sen. Debbie Clary; Sen. Thom Goolsby; Sen. David Rouzer; Sen. William Purcell; Sen. Fletcher Hartsell, Jr.; Rep. Jennifer Weiss; Sen. Eric Mansfield; Sen. James Forrester; Rep. Beverly Earle; Rep. Jean Farmer-Butterfield; Rep. Mark Hollo
Cc: Lynn Tennant (Sen. Clary); Morgan Beam (Sen. Goolsby); Judy Edwards (Sen. Rouzer); Becky Hedspeth (Sen. Purcell); Gerry Johnson (Sen. Hartsell); Cindy Douglas (Rep. Weiss); Jackie Ray (Sen. Mansfield); Mona Fitzgerald (Sen. Forrester); Ann Raeford (Rep. Earle); Sherrie Burnette (Rep. Farmer-Butterfield); Carol Wakely (Rep. Hollo)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wed, 05-11-2011 at 11:00 AM - CORRECTED

Principal Clerk _____
Reading Clerk _____

2nd Corrected: Add SB512

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 11, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 743	Encourage Volunteer Health Care Providers.	Senator Goolsby
SB 644	DSS Adoption Assistance Agreements Binding.	Senator Rouzer
SB 471	Youth Skin Cancer Prevention Act.	Senator Mansfield Senator Forrester Senator Purcell
IB 474	Protect Adult Care Home Residents.	Representative Earle Representative Farmer-

SB 670	Revise Membership/Hearing Aid Fitters Board.	Butterfield Representative Weiss Representative Hollo Senator Hartsell
SB 512	Adult Day Care/Overnight Respite Program.	Senator Clary
		Senator Stan Bingham, Co-Chair Senator Harris Blake, Co-Chair Senator Louis Pate, Co-Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, May 11, 2011

Room 544 LOB

11:00 AM

Senator Louis Pate, Presiding

AGENDA

WELCOME AND OPENING REMARKS

BILLS TO BE CONSIDERED

SB 743 Encourage Volunteer Health Care Providers

SB 644 DSS Adoption Assistance Agreements Binding

SB 471 Youth Skin Cancer Prevention Act

HB 474 Protect Adult Care Home Residents

SB670 Revise Membership/Hearing Aid Fitters Board

SB 512 Adult Day Care/Overnight Respite Program

BILL SPONSORS

Senator Goolsby

Senator Rouzer

Senator Mansfield

Senator Forrester

Senator Purcell

Representative Earle

Representative Farmer-
Butterfield

Representative Weiss

Representative Hollo

Senator Hartsell

Senator Clary

OTHER BUSINESS

ADJOURNMENT

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Thursday, May 12, 2011

Senator PATE,

submits the following with recommendations as to passage:

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

S.B.	471	Youth Skin Cancer Prevention Act.	
		Draft Number:	75159
		Sequential Referral:	None
		Recommended Referral:	Commerce
		Long Title Amended:	No
S.B.	512	Adult Day Care/Overnight Respite Program.	
		Draft Number:	55301
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes
S.B.	644	DSS Adoption Assistance Agreements Binding.	
		Draft Number:	85198
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes
S.B.	670	Revise Membership/Hearing Aid Fitters Board.	
		Draft Number:	85199
		Sequential Referral:	None
		Recommended Referral:	Finance
		Long Title Amended:	Yes

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO
SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1) 474	Protect Adult Care Home Residents.	
	Draft Number:	80223
	Sequential Referral:	None
	Recommended Referral:	None
	Long Title Amended:	No

TOTAL REPORTED: 5

Committee Clerk Comments:

HB 474 -- Sen. Pate or Sen. Bingham will handle on Floor.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 471
PROPOSED COMMITTEE SUBSTITUTE S471-PCS75159-SQ-13

Short Title: Youth Skin Cancer Prevention Act.

(Public)

Sponsors:

Referred to:

March 31, 2011

A BILL TO BE ENTITLED
AN ACT TO RAISE THE AGE FOR WHICH USE OF TANNING EQUIPMENT REQUIRES
A WRITTEN PRESCRIPTION.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as the Youth Skin Cancer Prevention Act of 2011.

SECTION 2. G.S. 104E-9.1(a) reads as rewritten:

"§ 104E-9.1. Restrictions on use and operation of tanning equipment.

(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person ~~13 years and younger~~ less than 18 years of age to use tanning equipment without a written prescription from the person's medical physician specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.

(3) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits.

...."

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



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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 512
PROPOSED COMMITTEE SUBSTITUTE S512-CSSH-17 [v.2]

5/5/2011 11:43:44 AM

Short Title: Authorize Overnight Respite Pilot.

(Public)

Sponsors:

Referred to:

April 6, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
3 TO PILOT AN OVERNIGHT RESPITE PROGRAM IN FACILITIES THAT OFFER
4 ADULT DAY CARE.

5 Whereas the population of adults who are elderly or disabled in North Carolina is expected
6 to increase, thereby increasing the need for safe and available overnight respite care;

7 Whereas adult day care provides group care and supervision to adults who may be
8 physically or mentally disabled; and

9 Whereas adult day care provides care and supervision during the day allowing caregivers a
10 time of respite or allowing caregivers to attend to other duties, including work; and

11 Whereas, adult day care allows individuals to remain in their communities and/or in
12 familiar surroundings, thereby prolonging or eliminating the need for placement in a long-term
13 care facility; Now therefore,

14 The General Assembly of North Carolina enacts:

15 **SECTION 1(a).** Notwithstanding G.S. 131D-6(b), the Department of Health and
16 Human Services shall conduct a pilot program to assess the provision of overnight respite
17 services in adult day care programs. The Secretary shall select a minimum of two, and a
18 maximum of four, stable and successful certified adult day care programs in which to conduct
19 the pilot. At least two of the programs selected shall be operated by an organization that has
20 been offering adult day care in North Carolina since 1980, and has received national
21 recognition including all of the following criteria: designated as a National Model Adult Day
22 Care Center by the Robert Wood Johnson Foundation, designated as the only Teaching Day
23 Center for recipients of North Carolina adult day care startup funds, received the North
24 Carolina Non-Profit Center's Non-Profit Sector Stewardship Award for exemplary stewardship
25 of resources, and received Leadership in Energy and Environmental Design (LEED)
26 certification.

27 **SECTION 1.(b)** The provision of 24-hour care under this act shall not exceed 14
28 consecutive calendar days, or more than 60 total calendar days, during a 365-day period, for
29 each participant receiving overnight respite services. The capacity of the 24-hour overnight
30 respite program authorized under this act shall not exceed six beds. The State is not authorized
31 to pay for any overnight respite services offered through this pilot and the pilot shall not be
32 eligible to enroll or otherwise participate in the Medicaid program.

33 **SECTION 1(c).** An adult day care program participating in this pilot shall be
34 currently certified by the Department to provide adult day care. An adult day care program



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1 participating in the pilot shall be exempt from adult care home licensure pursuant to Chapter
2 131D, Article 1 of the General Statutes and shall be exempt from licensure under Chapter 131E
3 and Chapter 122C of the General Statutes. The Department of Health and Human Services
4 shall adopt rules to include minimum requirements to ensure the health and safety of adult day
5 care overnight respite participants. These requirements shall specify program management,
6 staffing, building specifications, fire safety, sanitation, nutrition, enrollment, medication
7 management, and program activities. Participant assessments conducted by the adult day care
8 pilot programs shall provide sufficient information to ensure appropriate care and to protect the
9 health and safety of participants, but shall not be more onerous than current adult day care
10 assessments. The Division of Health Service Regulation shall have the authority to enforce the
11 rules adopted by the Department. Prior to the provision of overnight respite services, an adult
12 day care program participating in the pilot shall receive an initial inspection by the Division of
13 Health Service Regulation for compliance with the rules. On a basis not less than every six
14 months, the Division of Health Service Regulation shall conduct monitoring visits and shall
15 also be responsible for the investigation of complaints. Each adult day care program
16 participating in the pilot shall periodically report the number of individuals served and the
17 average daily census to the Division of Health Service Regulation, on a schedule determined by
18 the Division. The Division of Health Service Regulation shall have the authority to suspend
19 admissions or terminate the pilot program at any time due to noncompliance with regulatory
20 requirements which has resulted in death or serious physical harm, or when there is a
21 substantial risk that death or serious physical harm will occur.

22 **SECTION 2.** The Department of Health and Human Services shall report on
23 the status of the pilot once a year to the Program Evaluation Division. The Program Evaluation
24 Division shall evaluate the provision of overnight respite services in an adult day care program
25 through the experiences of this pilot. The evaluation shall include whether this pilot was
26 successful as measured by the participants in receipt of overnight respite, the primary
27 caregivers of participants, the adult day care programs participating in the pilot, and the
28 Department of Health and Human Services. On or before October 1, 2014, the Program
29 Evaluation Division shall provide a report to the General Assembly on the feasibility of
30 continuing to provide overnight respite in an adult day care program.

31 **SECTION 3.** This act becomes effective when it becomes law, adult day care
32 programs participating in the pilot shall be selected and have received an initial inspection by
33 January 1, 2012, and the act is repealed June 1, 2015.
34

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 512

Short Title: Adult Day Care/Overnight Respite Program.

(Public)

Sponsors: Senators Clary; and Pate.

Referred to: Health Care.

April 6, 2011

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH ADULT DAY CARE/OVERNIGHT RESPITE PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-6 reads as rewritten:

"§ 131D-6. ~~Certification of adult~~ Adult day care and adult day care/overnight respite programs. ~~programs; purpose; definition; penalty.~~

(a) Policy. – It is the policy of this State to enable people who would otherwise need full-time care away from their own residences to remain in their residences usual place of abode to remain in their communities with their friends and families as long as possible and to enjoy as much independence as possible. ~~One of the programs~~ Adult day care and adult day care/overnight respite are two programs that permits ~~permit~~ adults to remain in their residences and with their families. ~~families is adult day care.~~

(a1) Rules. – The Social Services Commission shall adopt rules to protect the health, safety, and welfare of persons in adult day care programs and adult day care/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. The Social Services Commission shall also adopt rules concerning the imposition of civil penalties for a violation of this section or of rules adopted. The Department of Health and Human Services shall enforce the rules of the Social Services Commission.

(a2) Inspection and Certification. – The Department of Health and Human Services shall annually inspect and certify all adult day care programs and adult day care/overnight respite programs under rules adopted by the Social Services Commission.

(a3) Transportation. – Adult day care programs are not required to provide transportation to participants; however, those programs that choose to provide transportation shall comply with rules adopted by the Commission for the health and safety of participants during transport.

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

(1) Adult day care program. – ~~As used in this section "adult day care program" means the provision of~~ A program that is inspected and certified by the Department as eligible to provide group care and supervision in a place other than ~~their~~ the individual's usual place of abode provided on a less than 24-hour basis to adults who may be physically or mentally disabled. ~~The Department of Health and Human Services shall annually inspect and certify all adult day care programs, under rules adopted by the Social Services Commission. The Social Services Commission shall adopt rules to protect the health, safety, and welfare of persons in adult day care programs. These rules shall include minimum standards relating to management~~



* S 5 1 2 - V - 1 *

of the program, staffing requirements, building requirements, fire safety, sanitation, nutrition, and program activities. Adult day care programs are not required to provide transportation to participants; however, those programs that choose to provide transportation shall comply with rules adopted by the Commission for the health and safety of participants during transport.

(2) Adult day care/overnight respite program. – A program that is inspected and certified by the Department as eligible to provide 24-hour group care and supervision to adults who may be physically or mentally disabled. This 24-hour care must be provided by a certified adult day care program and shall not exceed 10 consecutive calendar days, or more than 60 total calendar days during a 365-day period. The provision of this service does not obligate the State to pay for any services not already authorized.

(3) Certified adult day care program. – An adult day care program that has completed at least one annual inspection and certification cycle and has not been found guilty of any violations in the last year.

(4) Special care services. – Programs, services, or activities designed especially for participants with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition as determined by the Medical Care Commission.

~~The Department of Health and Human Services shall enforce the rules of the Social Services Commission.~~

(b1) Adult Day Care Program Advertising Special Care Services. – An adult day care program that provides or that advertises, markets, or otherwise promotes itself as providing special care services for persons with Alzheimer's disease or other dementias, a mental health disability, or other special needs disease or condition shall provide the following written disclosures to the Department and to persons seeking adult day care program special care services:

- (1) A statement of the overall philosophy and mission of the adult day care program and how it reflects the special needs of participants with dementia.
- (2) The process and criteria for providing or discontinuing special care services.
- (3) The process used for assessment and establishment of the plan of care and its implementation, including how the plan of care is responsive to changes in the participant's condition.
- (4) Staffing ratios and how they meet the participant's need for increased special care and supervision.
- (5) Staff training that is dementia-specific.
- (6) Physical environment and design features that specifically address the needs of participants with Alzheimer's disease or other dementias.
- (7) Frequency and type of participant activities provided.
- (8) Involvement of families in special care and availability of family support programs.
- (9) Additional costs and fees to the participant for special care.

(b2) Written Disclosure Review. – As part of its certification renewal procedures and inspections, the Department shall examine for accuracy the written disclosure of each adult day care program subject to this section. Substantial changes to written disclosures shall be reported to the Department at the time the change is made.

(b3) Adult Day Care Program Not Advertising Special Care Services. – Nothing in this section shall be construed as prohibiting an adult day care program that does not advertise, market, or otherwise promote itself as providing special care services for persons with

1 Alzheimer's disease or other dementias from providing adult day care services to persons with
2 Alzheimer's disease or other dementias, a mental health disability, or other special needs
3 disease or condition.

4 ~~(b4) As used in this section, the term "special care service" means a program, service, or~~
5 ~~activity designed especially for participants with Alzheimer's disease or other dementias, a~~
6 ~~mental health disability, or other special needs disease or condition as determined by the~~
7 ~~Medical Care Commission.~~

8 (c) Violations and Penalties. – The Secretary may impose a civil penalty not to exceed
9 one hundred dollars (\$100.00) for each violation on a person, firm, agency, or corporation who
10 willfully violates any provision of this section or any rule adopted by the Social Services
11 Commission pursuant to this section. Each day of a continuing violation constitutes a separate
12 violation.

13 In determining the amount of the civil penalty, the Secretary shall consider the degree and
14 extent of the harm or potential harm caused by the violation.

15 ~~The Social Services Commission shall adopt rules concerning the imposition of civil~~
16 ~~penalties under this subsection.~~

17 The clear proceeds of civil penalties imposed pursuant to this subsection shall be remitted
18 to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

19 (c1) Offense. – Any person, firm, agency, or corporation that harms or willfully neglects
20 a person under its care is guilty of a Class 1 misdemeanor.

21 (d) Exemptions From This Section. – The following programs are exempted from the
22 provisions of this section:

23 (1) Those that care for three people or less;

24 (2) Those that care for two or more persons, all of whom are related by blood or
25 marriage to the operator of the facility;

26 (3) Those that are required by other statutes to be licensed by the Department of
27 Health and Human Services."

28 **SECTION 2.** The Social Services Commission shall adopt rules to establish adult
29 day care/overnight respite programs.

30 **SECTION 3.** Section 1 of this act becomes effective January 1, 2012; the
31 remainder of this act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

S

D

**SENATE BILL 644
PROPOSED COMMITTEE SUBSTITUTE S644-PCS85198-TK-10**

Short Title: DSS Adoption Assistance Agreements Binding.

(Public)

Sponsors:

Referred to:

April 19, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DIVISION OF SOCIAL SERVICES, TO REQUIRE A REDETERMINATION OF
ELIGIBILITY FOR VENDOR PAYMENTS ONLY IF THE ADOPTION ASSISTANCE
AGREEMENT SPECIFICALLY REQUIRES A REDETERMINATION TO RECEIVE
VENDOR PAYMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Except as otherwise prohibited by federal law, the Department of
Health and Human Services, Division of Social Services, shall not require a redetermination of
a child's eligibility for vendor payments under any adoption assistance agreement, as outlined
in 10A NCAC 70M .0402, unless the adoption assistance agreement clearly and specifically
states that a redetermination of a child's eligibility is required to receive the vendor payments.

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



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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 670
PROPOSED COMMITTEE SUBSTITUTE S670-PCS85199-SQ-27

Short Title: Revise Membership/Hearing Aid Fitters Board.

(Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT RELATING TO HEARING AID FITTING AND DISPENSING BY CERTAIN
LICENSED AUDIOLOGISTS AND REVISING THE MEMBERSHIP ON THE NORTH
CAROLINA STATE HEARING AID DEALERS AND FITTERS BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 93D-2 reads as rewritten:

"§ 93D-2. Fitting and selling without license unlawful.

It shall be unlawful for any person to fit or sell hearing aids unless ~~he~~the person has first obtained a license from the North Carolina State Hearing Aid Dealers and Fitters BoardBoard, or obtained a license under Article 22 of Chapter 90 of the General Statutes and possesses a doctoral degree in audiology (AuD), or is an apprentice working under the supervision of a board licensee either such licensee and is registered in accordance with G.S. 93D-9."

SECTION 2. G.S. 93D-3(a) reads as rewritten:

"(a) There is hereby created a board whose duty it shall be to carry out the purposes and enforce the provisions of this Chapter, and which shall be known as the "North Carolina State Hearing Aid Dealers and Fitters Board." The Board shall be composed of seven members. Four members who have been actively engaged in the fitting and selling of hearing aids for three years pursuant to licensure under this Chapter shall be appointed by the Governor. These initial appointments are for the following terms: one for one year, one for two years, one for three years and one for four years. All appointments made on or after July 1, 1981, shall be for terms of three years.

One member shall be appointed by the Governor who shall be a physician practicing in North Carolina, preferably specializing in the field of otolaryngology. All appointments shall be for terms of three years.

One member, who shall be a person with hearing loss, shall be appointed by the Governor to represent the interest of hearing aid consumers from a list of two audiologists residing in North Carolina, which list shall be compiled by the North Carolina Speech and Hearing Association. This initial appointment shall be for a term of three years. All appointments made on or after July 1, 1981, shall be for a term of three years.

One member shall be appointed by the Governor to represent the interest of the public at large. This member shall have no ties to the hearing aid business nor shall he be an audiologist. The Governor shall appoint the public member not later than July 1, 1981, to serve a term of three years.



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1 All Board members serving on June 30, 1981, shall be eligible to complete their respective
2 terms. No member appointed to a term on or after July 1, 1981, shall serve more than two
3 complete consecutive terms.

4 Vacancies on the Board shall be filled by appointment of the Governor. Appointees shall
5 serve the unexpired term of their predecessor in office and must be appointed from the same
6 category as their predecessor in office. The members of the Board, before entering their duties,
7 shall respectively take all oaths taken and prescribed for other State officers, in the manner
8 provided by law, which oaths shall be filed in the office of the Secretary of State, and the Board
9 shall have a common seal."

10 **SECTION 3.** G.S. 93D-3(c)(14) reads as rewritten:

11 "(14) Have the power to set and collect fees in accordance with Chapter 150B of
12 the General Statutes for the items listed in this subdivision and for other
13 items for which this Chapter gives the Board the authority to set a fee:

- 14 a. For a continuing education make-up class provided by the Board, a
15 fee not to exceed fifty dollars (\$50.00) per person for each day of
16 instruction. The Board may not offer a make-up class that is longer
17 than two days;
- 18 b. For a license examination preparation course provided by the Board,
19 a fee not to exceed fifty dollars (\$50.00) per person for each day of
20 instruction. The Board may not offer an examination preparation
21 course that is longer than three days;
- 22 c. For approval of a continuing education program provider, a fee not to
23 exceed forty dollars (\$40.00);
- 24 d. For verifying and recording attendance at a continuing education
25 program not provided by the Board, a fee not to exceed fifteen
26 dollars (\$15.00) per licensee per program;
- 27 e. For providing a voluntary two-day apprentice training workshop, a
28 fee not to exceed one hundred dollars (\$100.00) per person, and for
29 providing a three-day voluntary apprentice training workshop, a fee
30 not to exceed one hundred fifty dollars (\$150.00) per person;
- 31 f. For administering an examination, a fee of three hundred dollars
32 (\$300.00); and (\$300.00);
- 33 g. For the registration of persons not licensed under this Chapter
34 providing supervision of apprentices registered under G.S. 93D-9, a
35 fee of one hundred fifty dollars (\$150.00) per annum; and".

36 **SECTION 4.** G.S. 93D-5(a) reads as rewritten:

37 "(a) Except as provided in G.S. 93D-2, no ~~no~~ person shall begin the fitting and selling of
38 hearing aids in this State unless the person has been issued a license by the Board or is an
39 apprentice working under the supervision of a ~~licensee~~ person authorized to fit and sell hearing
40 aids in this State. Except as hereinafter provided, each applicant for a license shall pay a fee set
41 by the Board, not to exceed two hundred fifty dollars (\$250.00), which fee may be prorated by
42 the Board, and shall show to the satisfaction of the Board that the applicant:

- 43 (1) Is a person of good moral character.
- 44 (2) Is 18 years of age or older.
- 45 (3) Has an education equivalent to a four-year course in an accredited high
46 school.
- 47 (4) Repealed by Session Laws 2007-406, s. 3, effective August 21, 2007."

48 **SECTION 5.** G.S. 93D-9 reads as rewritten:

49 "**§ 93D-9. Registration of apprentices.**

1 (a) Any person age 17 or older may apply to the Board for registration as an apprentice.
2 Each applicant must be sponsored by a ~~hearing aid dealer and fitter licensed by the~~
3 ~~Board.~~person authorized to fit and sell hearing aids in this State.

4 (b) Upon receiving an application accompanied by a fee in an amount set by the Board,
5 not to exceed one hundred dollars (\$100.00), the Board may register the applicant as an
6 apprentice, which shall entitle the applicant to fit and sell hearing aids under the supervision of
7 ~~a holder of a regular license.~~a person authorized to fit and sell hearing aids in this State.

8 (c) No applicant shall be registered as an apprentice by the Board under this section
9 unless the applicant shows to the satisfaction of the Board that the applicant is or will be
10 supervised and trained by a ~~hearing aid fitter and seller who holds a license.~~person authorized
11 to fit and sell hearing aids in this State.

12 (d) If a person 18 years of age or older who is registered as an apprentice under this
13 section does not take the next succeeding examination given after a minimum of one full year
14 of apprenticeship, the person's apprentice registration shall not be renewed, except for good
15 cause shown to the satisfaction of the Board.

16 (e) If a person who is registered as an apprentice takes and fails to pass the next
17 succeeding examination given after one full year of apprenticeship, the Board may renew the
18 apprenticeship license for a period of time to end 30 days after the results of the examination
19 given next after the date of renewal of said registration. The fee for renewal of apprenticeship
20 registration shall be set by the Board at an amount not to exceed one hundred fifty dollars
21 (\$150.00).

22 (f) The Board shall adopt rules implementing initial and renewal registration of
23 apprentices."

24 **SECTION 6.** The terms of the two audiologist members currently serving on the
25 North Carolina State Hearing Aid Dealers and Fitters Board (Board) shall expire on the
26 effective date of this act. Vacancies on the Board pursuant to this section shall be filled in
27 accordance with G.S. 93D-3.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

D

HOUSE BILL 474
Committee Substitute Favorable 4/26/11
Third Edition Engrossed 4/28/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H474-PCS80223-TK-13

Short Title: Protect Adult Care Home Residents.

(Public)

Sponsors:

Referred to:

March 28, 2011

A BILL TO BE ENTITLED
AN ACT TO PROTECT ADULT CARE HOME RESIDENTS BY INCREASING MINIMUM
CONTINUING EDUCATION, TRAINING, AND COMPETENCY EVALUATION
REQUIREMENTS FOR ADULT CARE HOME MEDICATION AIDES,
STRENGTHENING ADULT CARE HOME INFECTION CONTROL REQUIREMENTS,
AND REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DIVISION OF HEALTH SERVICE REGULATION, TO ANNUALLY INSPECT
ADULT CARE HOMES FOR COMPLIANCE WITH SAFE INFECTION CONTROL
STANDARDS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-4.5(1) reads as rewritten:

- "(1) Establishing minimum medication administration standards for adult care homes. The rules shall include the minimum staffing and training requirements for medication aides and standards for professional supervision of adult care homes' medication controls. The requirements shall (i) include compliance with G.S. 131D-4.5B and (ii) be designed to reduce the medication error rate in adult care homes to an acceptable level. The requirements shall include, but need not be limited to, all of the following:
- a. Training for medication aides, including periodic refresher training.
 - b. Standards for management of complex medication regimens.
 - c. Oversight by licensed professionals.
 - d. Measures to ensure proper storage of medication."

SECTION 2. G.S. 131D-4.5(3) reads as rewritten:

- "(3) Establishing minimum training and education qualifications for supervisors in adult care homes and specifying the safety responsibilities of supervisors. The minimum training qualifications shall include compliance with G.S. 131D-4.5C."

SECTION 3. Article 1 of Chapter 131D of the General Statutes is amended by adding two new sections to read:

"§ 131D-4.4A. Adult care home infection prevention requirements.

(a) As used in this section, "adult care home staff" means any employee of an adult care home involved in direct resident care.



* H 4 7 4 - P C S 8 0 2 2 3 - T K - 1 3 *

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:

- (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following:
 - a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents.
 - b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.
 - c. Accessibility of infection control devices and supplies.
 - d. Blood and bodily fluid precautions.
 - e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.
 - f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.
- (2) Require and monitor compliance with the facility's infection control policy.
- (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.
- (4) Designate one on-site staff member for each noncontiguous facility who is knowledgeable about the federal Centers for Disease Control and Prevention guidelines on infection control to direct the facility's infection control activities and ensure that all adult care staff is trained in the facility's infection control policy. Beginning October 1, 2013, any nonsupervisory staff member designated to direct the facility's infection control activities shall complete the infection control course developed by the Department pursuant to G.S. 131D-4.5C.

"§ 131D-4.4B. Guidelines for reporting suspected communicable disease outbreaks.

The Department shall develop guidelines prescribing the manner in which an adult care home is to report a suspected communicable disease outbreak within the facility to the local health department."

SECTION 4. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements."

SECTION 5. Article 1 of Chapter 131D of the General Statutes is amended by adding two new sections to read:

"§ 131D-4.5B. Adult care home medication aides; training and competency evaluation requirements.

(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5.

(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:

(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:

a. The key principles of medication administration.

b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.

(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.

(3) Within 60 days from the date of hire, the individual must have completed the following:

a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:

1. The key principles of medication administration.

2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.

b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

(c) By October 1, 2012, the Division of Health Service Regulation shall develop and administer an examination for individuals seeking employment as a medication aide in an adult care home.

"§ 131D-4.5C. Adult care home supervisors; infection control training requirements.

By December 1, 2011, the Department shall develop a mandatory, annual course for adult care home supervisors on federal Centers for Disease Control and Prevention guidelines on infection control. Each supervisor that successfully completes the mandatory infection control course shall receive credit, in an amount determined by the Department, toward the continuing education requirements for adult care home supervisors established by the Commission pursuant to G.S. 131D-4.5."

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

VISITOR REGISTRATION SHEET

Health Committee

5-11-11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

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John Dean	Gurw's Office
Pennis Streets	NC- DAAS
Teresa Johnson	NC ADSA
ID DONALDSON	SULLY Palm Beach Tan
Tham Ma	Truck U Udon
CHIP CAMPBELL	FOUR SEASONS TRAINING, INC.
Jeff Morton	DAAS- JHSR
Jesse Gopalan	" "
Sam Hoon	XENA
Emily grimm	MVC

VISITOR REGISTRATION SHEET

Health Committee

5-11-11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

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Pharm Assoc.

W. Gordon Pugh

NIC & Assoc
NC Dept. Health and Human Svcs.
Division of Social Services

R. Patrick Betancourt

Zack Moore

Dir of Public Health

Megan Davies

Div. of Public Health

Constance D. Jones

Dir of Public Health

Daniel Mallison, III

Beaufort Regional Health System

Paula Hopper

Choleraist

Clell Hamm

J. Clell Hamm

Michelle Brooks

UHS

Gretchen Kelly

FHC

VISITOR REGISTRATION SHEET

Health Committee

5-11-11

Name of Committee

Date

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Christine Weason	American Cancer Society
Betsy Vetter	American Heart Assoc
Kristi Morben	DHHS
Winnie Tung	UNC
Nicole Lee	UNC SOM
Josh Ryan	UNC SOM
Aimee Sanders MD	Dermatology Group of The Carolina Concord, NC
Pamela Fuesters	Pinehurst Dermatology
ROB CLARK	CARY SKIN CENTER
John Albertini	Skin Surgery Center
Kevin Stein	"
D. Todd DeVries	Central Dermatology Center

VISITOR REGISTRATION SHEET

Health Committee

5-11-11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patricia A Yancey	NCANP / APPC NC
Jean R. Deaton	NCANP 301 Weaver St. Cary, NC 22517
Holly Salter	DRNC
Anna Lee Ralph	DRNC
Quita Davis	
Erulyn Hawthorne	NCALIA; NCAP
John Risher	NCPS
Jon Carr	NC Pediatric Society
Steve Shore	NC Pediatric Soc.
Joe Donovan	Self
Kay Emanuel	Legislative Reporting Services

VISITOR REGISTRATION SHEET

Health Committee

5-11-11

Name of Committee

Date

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Tracy Colvard	AMAC
Rob Hamm	FLA
Erica Nelson	NCCCP
Melissa Turner	NCAAC
Alan Skipper	NCM 5
Elizabeth Hodgins	CFTF
Tom V. Hays	CFTF
Barbara Carlson	BSCOR
John Bowditch	AstraZeneca
Jon Allen	BEGINNINGS
Jessie Bangum	NEIMS
Heather Barnett	Williams Muller
CS Hollis	TBS
Jennifer Mahan	ASNC

PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 5-11 TIME: 11 AM

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
1 Alexis McDonald	Raleigh	Phil Berger
2 Jessica Williford	Fuquay-Varina	Phil Berger
4		
5		
6		
7		
8		
9		
10		

Do not add names below the grid.

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

SENATE HEALTH CARE COMMITTEE

May 18, 2011

MINUTES

The Senate Health Care Committee met on Wednesday, May 18, 2011 in Room 544 of the Legislative Office Building. Fifteen members were in attendance along with staff Shawn Parker, Theresa Matula, Amy Jo Johnson, and Susan Barham.

Senator Bingham called the meeting to order at 11:06am and introduced the Pages. Senator Purcell made a motion to consider Proposed Committee Substitute S246 AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF IMMUNIZING PHARMACISTS (attached). The motion carried and the bill's sponsor, Senator Hartsell explained the bill. Comments were made from the audience by Dr. Jeffrey Engel, the State Health Director and Evelyn Hawthorn from the North Carolina Association of Pharmacists. After discussion, the Committee decided to appoint a sub-committee to study the bill, and S246 was tabled.

Senator Atwater made a motion to consider Proposed Committee Substitute S743 AN ACT TO ENCOURAGE THE PROVISION OF MEDICAL SERVICES TO INDIGENT PERSONS BY PROVIDING FOR A RETIRED LIMITED VOLUNTEER LICENSE AND BY BROADENING THE APPLICABILITY OF A LIMITED VOLUNTEER LICENSE AND BY LIMITING LIABILITY FOR NON-PROFIT COMMUNITY HEALTH REFERRAL SERVICES (attached). The motion carried and the bill's sponsor, Senator Goolsby explained the bill. Dr. Janelle Rhyne from the Cape Fear Health Net spoke on the bill from the audience. After questions and discussion, Senator Tucker made a motion which carried. The bill was reported as unfavorable as to bill, but favorable as to committee substitute bill. The bill was recommended to be referred to the Senate Finance Committee.

The next bill up for consideration was H160 AN ACT TO PROVIDE SPACE ON THE INCOME TAX RETURN FOR INDIVIDUALS TO MAKE DONATIONS FOR EARLY DETECTION OF BREAST AND CERVICAL CANCER AS PROVIDED BY THE BREAST AND CERVICAL CANCER CONTROL PROGRAM (attached). Representative Dollar explained his bill and invited Representative Justus to speak on the bill. After questions and discussion, Senator Atwater made a motion for a favorable report. The motion carried and the bill was reported out favorably in memory of Senator Tucker's mother.

Senator Hartsell made a motion to consider Proposed Committee Substitute S496 AN ACT RELATING TO REQUIREMENTS OF MEDICAID AND HEALTH CHOICE PROVIDERS (attached). The motion carried and the bill's sponsor, Senator Pate explained the bill. He was assisted in the explanation by Research staff member Amy Jo Johnson. Dr. Gray from the Department of Health and Human Services commented on the bill. After discussion, the bill was tabled.

The meeting was adjourned at 11:55.

Respectfully submitted,

Maria Kinnaird
Maria Kinnaird, Committee Assistant

Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-chair

Stan Bingham
Senator Stan Bingham, Presiding Chair

Principal Clerk _____
Reading Clerk _____

Corrected:

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 18, 2011	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell
SB 496	PPACA/Required Fraud and Abuse Provisions.	Senator Pate
SB 552	Regional Public Health Authority Pilot.	Senator Hartsell
SB 743	Encourage Volunteer Health Care Providers.	Senator Goolsby
HB 160	Check-Off Donation: Breast Cancer Screening.	Representative Justice Representative Dollar Representative Howard Representative Stevens

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee
Wednesday, May 18, 2011, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell
SB 496	PPACA/Required Fraud and Abuse Provisions.	Senator Pate
SB 552	Regional Public Health Authority Pilot.	Senator Hartsell
SB 743	Encourage Volunteer Health Care Providers.	Senator Goolsby
HB 160	Check-Off Donation: Breast Cancer Screening.	Representative Justice Representative Dollar Representative Howard Representative Stevens Representative Current Representative Dollar Representative Hollo
HJR 647	Diabetes Task Force.	

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Tuesday, May 24, 2011

Senator BINGHAM,

submits the following with recommendations as to passage:

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

S.B.	743	Encourage Volunteer Health Care Providers.
		Draft Number: 35252
		Sequential Referral: None
		Recommended Referral: Finance
		Long Title Amended: Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, May 18, 2011

Senator BINGHAM,

submits the following with recommendations as to passage:

FAVORABLE

H.B.	160	Check-Off Donation: Breast Cancer Screening.	
		Sequential Referral:	None
		Recommended Referral:	None

TOTAL REPORTED: 1

Committee Clerk Comments:

Senator Tucker will speak on the bill.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 246
PROPOSED COMMITTEE SUBSTITUTE S246-CSSQ-31 [v.5]

5/17/2011 3:14:20 PM

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors:

Referred to:

March 8, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
3 IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
4 IMMUNIZING PHARMACISTS.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. Not later than January 1, 2012, the Commission for Public Health
7 shall adopt rules to provide standards for the administration of immunizations by pharmacists
8 in accordance with G.S. 90-85.15. The rules shall include the following:

9 (a) A uniform protocol for any vaccine or immunization recommended or required by
10 the Centers for Disease Control and Prevention, and its application to specified categories of
11 individuals eligible to receive the vaccine. The protocol shall include any contraindications,
12 emergency procedures, information to be disclosed to patients, and a procedure for annual
13 updates on vaccine administration.

14 (b) Responsibilities of the local health department overseeing the immunizing
15 pharmacist. These responsibilities shall include recording keeping procedures for all
16 registrations and protocols pertaining to immunizing pharmacists registered at the local health
17 department, accessibility to the immunizing pharmacist for consultation, assistance, direction
18 and back-up coverage, annual review of qualifications of the immunizing pharmacist with the
19 ability to make revisions if necessary, and periodic status reports on patients seen by the
20 immunizing pharmacist.

21 (c) Registration of all immunizing pharmacists with a local supervising health
22 department and qualifications for maintaining status as an immunizing pharmacist.

23 (d) Procedures for record keeping and reporting by immunizing pharmacists.

24 (e) Procedures for the handling and disposal of drugs, used or contaminated equipment
25 or supplies.

26 SECTION 2. G.S. 90-85.3 is amended by adding the following new subsections to
27 read:

28 "(1) "Immunizing pharmacist" means a licensed pharmacist who meets all of the
29 following qualifications:

30 (1) Holds a current provider level cardiopulmonary resuscitation certification
31 issued by the American Heart Association or the American Red Cross, or an
32 equivalent certification.

33 (2) Has successfully completed a certificate program in vaccine administration
34 accredited by the Centers for Disease Control and Prevention, the



1 Accreditation Council for Pharmacy Education, or a similar health authority
2 or professional body approved by the Board.

3 (3) Maintains documentation of three hours of continuing education every two
4 years, designed to maintain competency in the disease states, drugs, and
5 vaccine administration.

6 (4) Has successfully completed training approved by the Division of Public
7 Health's Immunization Branch for participation in the North Carolina
8 Immunization Registry.

9 (5) Registers with a local supervising health department and pays an annual
10 registration fee.

11 (6) Administers vaccines or immunizations in accordance with G.S. 90-18.15B."

12 **SECTION 2.** G.S. 90-85.3(r) reads as rewritten:

13 "(r) "Practice of pharmacy" means the responsibility for: interpreting and evaluating
14 drug orders, including prescription orders; compounding, dispensing and labeling prescription
15 drugs and devices; properly and safely storing drugs and devices; maintaining proper records;
16 and controlling pharmacy goods and services. A pharmacist may advise and educate patients
17 and health care providers concerning therapeutic values, content, uses and significant problems
18 of drugs and devices; assess, record and report adverse drug and device reactions; take and
19 record patient histories relating to drug and device therapy; monitor, record and report drug
20 therapy and device usage; perform drug utilization reviews; and participate in drug and drug
21 source selection and device and device source selection as provided in G.S. 90-85.27 through
22 G.S. 90-85.31. A pharmacist who has received special training may be authorized and
23 permitted to administer drugs pursuant to a specific prescription order in accordance with rules
24 adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina
25 Medical Board. The rules shall be designed to ensure the safety and health of the patients for
26 whom such drugs are administered. An approved clinical pharmacist practitioner may
27 collaborate with physicians in determining the appropriate health care for a patient, subject to
28 the provisions of G.S. 90-18.4, is as specified in G.S. 90-85.3A."

29 **SECTION 3.** Article 4A of Chapter 90 of the General Statutes is amended by
30 adding a new section to read:

31 **"§ 90-85.3A. Practice of pharmacy.**

32 (a) A pharmacist is responsible for interpreting and evaluating drug orders, including
33 prescription orders; compounding, dispensing, and labeling prescription drugs and devices;
34 properly and safely storing drugs and devices; maintaining proper records; and controlling
35 pharmacy goods and services.

36 (b) A pharmacist may advise and educate patients and health care providers concerning
37 therapeutic values, content, uses, and significant problems of drugs and devices; assess, record,
38 and report adverse drug and device reactions; take and record patient histories relating to drug
39 and device therapy; monitor, record, and report drug therapy and device usage; perform drug
40 utilization reviews; and participate in drug and drug source selection and device and device
41 source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

42 (c) An immunizing pharmacist may be authorized and permitted to administer drugs
43 pursuant to a specific prescription order or pursuant to protocol in accordance with rules
44 adopted by the Commission for Public Health. The rules shall be designed to ensure the safety
45 and health of the patients for whom such drugs are administered.

46 (d) An approved clinical pharmacist practitioner may collaborate with physicians in
47 determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.

48 **SECTION 4.** Article 4A of Chapter 90 of the General Statutes is amended by
49 adding a new section to read:

50 **"§ 90-85.15B Immunizing pharmacists**

(a) An immunizing pharmacist may administer vaccines or immunizations in accordance to rules adopted by the Commission for Public Health with the following limitations:

- (1) Vaccines or immunizations shall not be administered to patients under the age of seven.
- (2) For patients at least seven years of age, but less than 14 years of age, influenza vaccines shall only be administered (i) pursuant to protocol, and (ii) at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.
- (3) For patients at least seven years of age, but less than 14 years of age, vaccines or immunizations other than influenza vaccine shall only be administered (i) pursuant to a specific prescription order, (ii) pursuant to protocol, and (iii) at the request of the patient's parent, guardian, or person standing in loco parentis to the minor.
- (4) For patients at least 14 years of age, but less than 18 years of age, vaccines or immunizations shall be administered pursuant to protocol, at the request of the of the patient's parent, guardian, or person standing in loco parentis to the minor either with or without a specific prescription order.
- (5) For patients at least 18 years of age, vaccines or immunizations shall be administered pursuant to protocol, at the request of the patient either with or without a specific prescription order.

(c) An immunizing pharmacist who administers a vaccine or immunization to any patient pursuant to this section shall do all of the following:

- (1). Maintain a record of any vaccine or immunization administered to the patient in a patient profile.
- (2). If the patient has identified a primary care provider, notify the patient's primary care provider of any vaccine or immunization administered to the patient within 24 hours after administration.
- (3). Record any vaccine or immunization administered to the patient in the North Carolina Immunization Registry within 24 hours after administration."

SECTION 5. G.S. 130A-29(c) is amended by adding a new subdivision to read:

"(11) Implementing the administration of vaccines and immunizations by immunizing pharmacists in accordance with G.S.90-85.15B.

SECTION 6. G.S. 130A-39(g) reads as rewritten:

"(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing", for services performed pursuant to G.S. 90-85.15B, and for services performed pursuant to G.S. 87-97. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

SECTION 7. G.S. 130A-153 reads as rewritten:

"(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or from medicine;~~ a local health ~~department.~~ department; or an immunizing pharmacist, in accordance with the provisions of G.S. 90-85.15B. Local health departments

1 shall administer required and State-supplied immunizations at no cost to uninsured or
2 underinsured patients with family incomes below two hundred percent (200%) of the federal
3 poverty level. A local health department may redistribute these vaccines only in accordance
4 with the rules of the Commission.

5 (b) Local health departments shall file monthly immunization reports with the
6 Department. The report shall be filed on forms prepared by the Department and shall state, at a
7 minimum, each patient's age and the number of doses of each type of vaccine administered.

8 (c) Immunization certificates and information concerning immunizations contained in
9 medical or other records shall, upon request, be shared with the Department, local health
10 departments, immunizing pharmacist, and the patient's attending physician. In addition, an
11 insurance institution, agent, or insurance support organization, as those terms are defined in
12 G.S. 58-39-15, may share immunization information with the Department. The Commission
13 may, for the purpose of assisting the Department in enforcing this Part, provide by rule that
14 other persons may have access to immunization information, in whole or in part.

15 (d) A ~~physician-physician~~, immunizing pharmacist, or local health department may
16 immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to
17 the minor. A ~~physician-physician~~, immunizing pharmacist, or local health department may also
18 immunize a minor who is presented for immunization by an adult who signs a statement that he
19 or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to
20 obtain the immunization for the minor. Notwithstanding any other provision of this Chapter, an
21 immunizing pharmacist's authority to administer vaccines or immunizations to a minor is
22 limited to the authority specified in G.S. 90-85.15B."

23 **SECTION 8.** G.S. 130A-154(a) reads as rewritten:

24 "(a) A ~~physician-physician~~, immunizing pharmacist, or local health department
25 administering a required vaccine shall give a certificate of immunization to the person who
26 presented the child for immunization. The certificate shall state the name of the child, the name
27 of the child's parent, guardian, or person responsible for the child obtaining the required
28 immunization, the address of the child and the parent, guardian or responsible person, the date
29 of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the
30 doses were given, the name and address of the ~~physician-physician~~, immunizing pharmacist, or
31 local health department administering the required immunization and other relevant
32 information required by the Commission."

33 **SECTION 9.** 21 NCAC 46.2507 shall govern the administration of influenza,
34 pneumococcal and zoster vaccines by pharmacists until rules adopted to implement provisions
35 of this act become effective, provided however an immunizing pharmacists shall be granted the
36 authority to administer influenza vaccine to patients aged 14 years and older.

37 **SECTION 10.** This act becomes effective October 1, 2011.



SENATE BILL 246: Expand Pharmacists' Immunizing Authority

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S246-CSSQ-31

Date: May 18, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *The Proposed Committee Substitute to Senate Bill 246 authorizes an "immunizing pharmacist" (defined term) to administer certain vaccines or immunizations pursuant to protocols developed by the Commission for Public Health with additional restrictions based on vaccine type or patient age.*

CURRENT LAW: Currently a pharmacist who has received special training is permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by the Board of Pharmacy, Board of Nursing, and Board of Medicine.

The current rule provides standards for pharmacists engaged in the administration of influenza, pneumococcal and zoster vaccines for persons 18 years and older.

BILL ANALYSIS: Senate Bill 246 amends the Pharmacy Practice Act as follows:

Section 1 directs the Commission for Public Health to adopt rules by January 1, 2012, to provide standards for the administration of vaccines by pharmacists. The rules shall include: protocols per each vaccine recommended or required by the CDC and its application to categories of individuals to receive the vaccine; responsibilities of local health departments in overseeing the immunizing pharmacist, registration and additional requirements of immunizing pharmacists including record keeping, reporting, and safe handling of vaccines.

Section 2 defines the term "immunizing pharmacist" as a licensed pharmacist who holds a current CPR certification, completed a certificate program in vaccine administration, maintains documentation of continuing education in vaccine administration, has successfully completed training for participation in the NC Immunization Registry, and administers vaccines or immunizations in accordance with the Article.

Sections 2* and 3 recodify the definition of the practice of pharmacy as a new section G.S. 90-85.3A, but change the authority for a specially trained pharmacist to administer drugs in accordance to rules adopted by the Commission for Public Health (was rules adopted by each of the Board of Pharmacy, Board of Nursing, and the North Carolina Medical Board).

Section 4 authorizes an immunizing pharmacist to administer vaccines or immunizations in accordance with rules and with the following limitations:

Age	Not Administered	Administered Pursuant to Written Protocol	At the Request of:	Specific Prescription Order
Under 7 Years Old	X		N/A	N/A
At Least 7 < 14 Years Old (Flu Vaccine)		X	Parent/Guardian	N/A

Senate PCS 246

Page 2

At Least 7 < 14 Years Old (Vaccines other than Flu)		X	Parent/Guardian	With
At Least 14 < 18 Years Old		X	Parent/Guardian	With or Without
At Least 18 Years Old		X	Patient	With or Without

and requires an immunizing pharmacist who administers vaccines or immunizations to do the following:

- Maintain a record of the vaccine or immunization administered in the patient profile.
- Notify the primary care provider (if the patient so identifies) within 24 hours of the administration.
- Record any vaccine or immunization in the NC Immunization Registry within 24 hours of the administration.

Section 5 provides the Commission of Public Health the authority to adopt rules to implement the act.

Section 6 provides local health departments the authority to charge a fee for services performed (registration, oversight) pursuant to rules adopted to implement the act.

Sections 7-8 make conforming changes in the public health law to provide for an immunizing pharmacist.

Section 9 provides that the current rule governing the administration of vaccines by pharmacists remains in effect until new rules adopted to implement the act are effective, but reduces the age of influenza vaccine recipients from 18 to 14.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S246-SMSQ-31(CSSQ-31) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 246

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors: Senators Hartsell; Atwater and Mansfield.

Referred to: Health Care.

March 8, 2011

A BILL TO BE ENTITLED
AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
IMMUNIZING PHARMACISTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.3(r) reads as rewritten:

"(r) "Practice of pharmacy" means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4 is as specified in G.S. 90-85.3A."

SECTION 2. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.3A. Practice of pharmacy.

(a) A pharmacist is responsible for interpreting and evaluating drug orders, including prescription orders; compounding, dispensing, and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services.

(b) A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses, and significant problems of drugs and devices; assess, record, and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record, and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

(c) A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by



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1 each of the following: The Board of Pharmacy, the Board of Nursing, and the North Carolina
2 Medical Board. The rules shall be designed to ensure the safety and health of the patients for
3 whom such drugs are administered.

4 (d) An approved clinical pharmacist practitioner may collaborate with physicians in
5 determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.

6 (e) A pharmacist who (i) holds a current provider level cardiopulmonary resuscitation
7 certification issued by the American Heart Association or the American Red Cross, or an
8 equivalent certification, (ii) has successfully completed a certificate program in vaccine
9 administration accredited by the Centers for Disease Control and Prevention, the Accreditation
10 Council for Pharmacy Education, or a similar health authority or professional body approved
11 by the Board, (iii) maintains documentation of three hours of continuing education every two
12 years, designed to maintain competency in the disease states, drugs, and vaccine administration,
13 and (iv) has successfully completed training approved by the Division of Public Health's
14 Immunization Branch for participation in the North Carolina Immunization Registry may
15 administer any vaccine or immunization recommended or required by the Centers for Disease
16 Control and Prevention, including a vaccine for travel outside the United States, subject to the
17 following limitations and requirements:

18 (1) A pharmacist may administer a vaccine or immunization to a minor who is
19 at least seven years of age, but less than 14 years of age, only (i) pursuant to
20 a specific prescription order and (ii) at the request of the minor's parent,
21 guardian, or person standing in loco parentis to the minor.

22 (2) A pharmacist may administer a vaccine or immunization without a specific
23 prescription order to a minor who is at least 14 years of age, but less than 18
24 years of age, only at the request of the minor's parent, guardian, or person
25 standing in loco parentis to the minor.

26 (3) A pharmacist may administer a vaccine or immunization without a specific
27 prescription order to any patient 18 years of age or older, at the patient's
28 request.

29 (4) A pharmacist who administers a vaccine or immunization to any patient
30 pursuant to this subsection shall do all of the following:

31 a. Maintain a record of any vaccine or immunization administered to
32 the patient in a patient profile.

33 b. If the patient has identified a primary care provider, notify the
34 patient's primary care provider of any vaccine or immunization
35 administered to the patient within 24 hours after administration.

36 c. Record any vaccine or immunization administered to the patient in
37 the North Carolina Immunization Registry within 24 hours after
38 administration."

39 **SECTION 3. G.S. 130A-153 reads as rewritten:**

40 "(a) The required immunization may be obtained from a physician licensed to practice
41 medicine or from medicine; a local health department; or a pharmacist, in
42 accordance with the provisions of G.S. 90-85.3A(e). Local health departments shall administer
43 required and State-supplied immunizations at no cost to uninsured or underinsured patients
44 with family incomes below two hundred percent (200%) of the federal poverty level. A local
45 health department may redistribute these vaccines only in accordance with the rules of the
46 Commission.

47 (b) Local health departments shall file monthly immunization reports with the
48 Department. The report shall be filed on forms prepared by the Department and shall state, at a
49 minimum, each patient's age and the number of doses of each type of vaccine administered.

50 (c) Immunization certificates and information concerning immunizations contained in
51 medical or other records shall, upon request, be shared with the Department, local health

1 departments, a pharmacist administering the required immunization in accordance with
2 G.S. 90-85.3A(e), and the patient's attending physician. In addition, an insurance institution,
3 agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may
4 share immunization information with the Department. The Commission may, for the purpose of
5 assisting the Department in enforcing this Part, provide by rule that other persons may have
6 access to immunization information, in whole or in part.

7 (d) A ~~physician~~ physician, pharmacist, or local health department may immunize a
8 minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A
9 ~~physician~~ physician, pharmacist, or local health department may also immunize a minor who is
10 presented for immunization by an adult who signs a statement that he or she is authorized by a
11 parent, guardian, or person standing in loco parentis to the minor to obtain the immunization
12 for the minor. Notwithstanding any other provision of this Chapter, a pharmacist's authority to
13 administer vaccines or immunizations to a minor is limited to the authority specified in
14 G.S. 90-85.3A(e)."

15 **SECTION 4.** G.S. 130A-154(a) reads as rewritten:

16 "(a) A ~~physician~~ physician, pharmacist, or local health department administering a
17 required vaccine shall give a certificate of immunization to the person who presented the child
18 for immunization. The certificate shall state the name of the child, the name of the child's
19 parent, guardian, or person responsible for the child obtaining the required immunization, the
20 address of the child and the parent, guardian or responsible person, the date of birth of the
21 child, the sex of the child, the number of doses of the vaccine given, the date the doses were
22 given, the name and address of the ~~physician~~ physician, pharmacist, or local health department
23 administering the required immunization and other relevant information required by the
24 Commission."

25 **SECTION 5.** This act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 743
PROPOSED COMMITTEE SUBSTITUTE S743-CSSQ-26 [v.1]

5/5/2011 10:24:55 AM

Short Title: Encourage Volunteer Health Care Providers.

(Public)

Sponsors:

Referred to:

April 20, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ENCOURAGE THE PROVISION OF MEDICAL SERVICES TO INDIGENT
3 PERSONS BY PROVIDING FOR A RETIRED LIMITED VOLUNTEER LICENSE AND
4 BY BROADENING THE APPLICABILITY OF A LIMITED VOLUNTEER LICENSE
5 AND BY LIMITING LIABILITY FOR NON-PROFIT COMMUNITY HEALTH
6 REFERRAL SERVICES.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. G.S. 90-12.1A reads as rewritten:

9 "§ 90-12.1A. Limited volunteer license.

10 (a) The Board may issue a "military limited volunteer license" to an applicant who:

11 (1) Has a license to practice medicine and surgery in another state; ~~state; and~~

12 (2) Produces a letter from the state of licensure indicating the ~~applicant is~~
13 ~~applicant's license is active and in good standing; and~~ standing.

14 (3) ~~Is authorized to treat personnel enlisted in a branch of the United States~~
15 ~~armed services or veterans.~~

16 (b) ~~The Board may issue a "retired limited volunteer license" to an applicant who is a~~
17 ~~retired physician and has allowed his or her license to practice medicine and surgery in this~~
18 ~~State or another state to become inactive.~~

19 (c) ~~A physician holding a limited license under this section shall comply with the~~
20 ~~continuing medical education requirements pursuant to rules adopted by the Board.~~

21 (d) The Board shall issue a limited license under this section within 30 days after an
22 applicant provides the Board with information satisfying the requirements of this section.

23 (e) The holder of a limited license under this section may practice medicine and surgery
24 only at clinics that specialize in the treatment of indigent patients. The holder of the limited
25 license may not receive compensation for services rendered at clinics specializing in the care of
26 indigent patients.

27 (e1) The holder of a limited volunteer license shall practice medicine and surgery within
28 this State for no more than 30 days per calendar year.

29 (f) The holder of a limited license issued pursuant to this section who practices
30 medicine or surgery at places other than clinics that specialize in the treatment of indigent
31 patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less
32 than twenty-five dollars (\$25.00) nor more than fifty dollars (\$50.00) for each offense. The
33 Board, in its discretion, may revoke the limited license after due notice is given to the holder of
34 the limited license.



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(g) The Board may, by rule, require an applicant for a limited license under this section to comply with other requirements or submit additional information the Board deems appropriate."

SECTION 2. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-12.1B. Retired limited volunteer license.

(a) The Board may issue a "retired limited volunteer license" to an applicant who is a physician and who has allowed his or her license to practice medicine and surgery in this State or another state to become inactive.

(b) A physician holding a limited license under this section shall comply with the continuing medical education requirements pursuant to rules adopted by the Board.

(c) The holder of a limited license under this section may practice medicine and surgery only at clinics that specialize in the treatment of indigent patients. The holder of the limited license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

(d) The Board shall issue a limited license under this section within 30 days after an applicant provides the Board with information satisfying the requirements of this section.

(e) The holder of a limited license issued pursuant to this section who practices medicine or surgery at places other than clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less than twenty-five dollars (\$25.00) nor more than fifty dollars (\$50.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

(f) The Board may, by rule, require an applicant for a limited license under this section to comply with other requirements or submit additional information the Board deems appropriate."

SECTION 3. G.S. 90-13.1 reads as rewritten:

"§ 90-13.1. License fees.

(a) Each applicant for a license to practice medicine and surgery in this State under either G.S. 90-9.1 or G.S. 90-9.2 shall pay to the North Carolina Medical Board an application fee of three hundred fifty dollars (\$350.00).

(b) Each applicant for a limited license to practice in a medical education and training program under G.S. 90-12.01 shall pay to the Board a fee of one hundred dollars (\$100.00).

(c) An applicant for a limited volunteer license under G.S. 90-12.1A or G.S. 90-12.1B shall not pay a fee.

(d) A fee of twenty-five dollars (\$25.00) shall be paid for the issuance of a duplicate license.

(e) All fees shall be paid in advance to the North Carolina Medical Board, to be held in a fund for the use of the Board.

(f) For the initial and annual licensure of an anesthesiologist assistant, the Board may require the payment of a fee not to exceed one hundred fifty dollars (\$150.00)."

SECTION 4. G.S. 90-13.2 reads as rewritten:

"§ 90-13.2. Registration every year with Board.

(a) Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday.

(b) A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay an annual registration fee of one hundred seventy-five dollars (\$175.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ~~(\$125.00) and (\$125.00).~~ those who have a retired limited volunteer license

1 pursuant to G.S. 90-12.1B shall pay an annual registration fee of twenty-five dollars (~~\$25.00~~;
2 ~~(\$25.00)~~, and those who have a limited volunteer license pursuant to G.S. 90-12.1A shall pay
3 no annual registration fee. However, licensees who have a limited license to practice for the
4 purpose of education and training under G.S. 90-12.01 shall not be required to pay more than
5 one annual registration fee for each year of training.

6 (c) A physician who is not actively engaged in the practice of medicine in North
7 Carolina and who does not wish to register the license may direct the Board to place the license
8 on inactive status.

9 (d) A physician who is not actively engaged in the practice of medicine in North
10 Carolina and who does not wish to register the license may direct the Board to place the license
11 on inactive status.

12 (e) A physician who fails to register as required by this section shall pay an additional
13 fee of fifty dollars (\$50.00) to the Board. The license of any physician who fails to register and
14 who remains unregistered for a period of 30 days after certified notice of the failure is
15 automatically inactive. The Board shall retain jurisdiction over the holder of the inactive
16 license.

17 (f) Except as provided in ~~G.S. 90-12.1A~~, G.S. 90-12.1B, a person whose license is
18 inactive shall not practice medicine in North Carolina nor be required to pay the annual
19 registration fee.

20 (g) Upon payment of all accumulated fees and penalties, the license of the physician
21 may be reinstated, subject to the Board requiring the physician to appear before the Board for
22 an interview and to comply with other licensing requirements. The penalty may not exceed the
23 maximum fee for a license under G.S. 90-13.1."

24 SECTION 5. G.S. 90-21.16 reads as rewritten:

25 "§ 90-21.16. Volunteer health care professionals; liability limitation.

26 (a) This section applies as follows:

- 27 (1) Any volunteer medical or health care provider at a facility of a local health
28 department or at a nonprofit community health center,
29 (2) Any volunteer medical or health care provider rendering services to a patient
30 referred by a local health department as defined in ~~G.S. 130A-2(5)~~
31 ~~or G.S. 130A-2(5)~~, nonprofit community health ~~center~~ center, or nonprofit
32 community health referral service at the provider's place of employment,
33 (3) Any volunteer medical or health care provider serving as medical director of
34 an emergency medical services (EMS) ~~agency~~ agency, or
35 (4) ~~Any retired physician holding a "Limited Volunteer License" under~~
36 ~~G.S. 90-12.1A, or~~
37 (5) Any volunteer medical or health care provider licensed or certified in this
38 State who provides services within the scope of the provider's license or
39 certification at a free clinic facility,

40 who receives no compensation for medical services or other related services rendered at the
41 facility, center, agency, or clinic, or who neither charges nor receives a fee for medical services
42 rendered to the patient referred by a local health ~~department or~~ department, nonprofit
43 community health ~~center~~ center, or nonprofit community health referral service at the provider's
44 place of employment shall not be liable for damages for injuries or death alleged to have
45 occurred by reason of an act or omission in the rendering of the services unless it is established
46 that the injuries or death were caused by gross negligence, wanton conduct, or intentional
47 wrongdoing on the part of the person rendering the services. The free clinic, local health
48 department facility, nonprofit community health center, nonprofit community health referral
49 service, or agency shall use due care in the selection of volunteer medical or health care
50 providers, and this subsection shall not excuse the free clinic, health department facility,

1 community health center, or agency for the failure of the volunteer medical or health care
2 provider to use ordinary care in the provision of medical services to its patients.

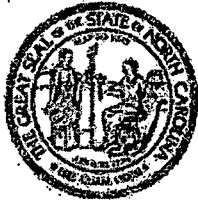
3 (b) Nothing in this section shall be deemed or construed to relieve any person from
4 liability for damages for injury or death caused by an act or omission on the part of such person
5 while rendering health care services in the normal and ordinary course of his or her business or
6 profession. Services provided by a medical or health care provider who receives no
7 compensation for his or her services and who voluntarily renders such services at the provider's
8 place of employment, facilities of free clinics, local health departments as defined in
9 G.S. 130A-2, nonprofit community health centers, or as a volunteer medical director of an
10 emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary
11 course of the volunteer medical or health care provider's business or profession.

12 (c) As used in this section, a "free clinic" is a nonprofit, 501(c)(3) tax-exempt
13 organization organized for the purpose of providing health care services without charge or for a
14 minimum fee to cover administrative costs and that maintains liability insurance covering the
15 acts and omissions of the free clinic and any liability pursuant to subsection (a) of this section.

16 (d) A nonprofit community health referral service that refers low-income patients to
17 physicians for free services is not liable for the acts or omissions of the physician in rendering
18 service to that patient if the ~~physician maintains professional liability coverage for that~~
19 ~~service.~~ nonprofit community health center maintains liability insurance covering the acts and
20 omissions of the nonprofit health referral service and any liability pursuant to subsection (a) of
21 this section.

22 (e) As used in this section, a "nonprofit community health referral service" is a
23 nonprofit, 501(c)(3) tax-exempt organization organized to provide for no charge the referral of
24 low-income, uninsured patients to volunteer health care providers who provide health care
25 services without charge to patients.

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



SENATE BILL 743: Encourage Volunteer Health Care Providers

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Goolsby
Analysis of: PCS to First Edition
S743-CSSQ-26

Date: May 10, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *Senate Bill 743 authorizes the North Carolina Medical Board to issue a "retired limited volunteer license" allowing certain physicians to practice surgery or medicine at clinics that specialize in the treatment of indigent patients and expands who may practice in this State under a limited volunteer license.*

The Proposed Committee Substitute includes nonprofit community health referral services within the limited liability provisions of law applicable to volunteer health care professionals.

CURRENT LAW: The North Carolina Medical Board is a 12 member board that regulates the practice of medicine and surgery in the State. The duties of the Board include the evaluation of applicants and issuance of the following licenses if the Board finds that the applicant meets specified qualifications: license to practice medicine and surgery, license to practice as physician assistant, resident's training license, retired limited volunteer license, military limited volunteer license, medical school faculty limited license, and physician assistant limited volunteer license. The Board's authority also includes the revocation, suspension, annulment, and denial of a license.

BILL ANALYSIS:

Senate Bill 743 broadens the applicability of a "limited volunteer license" by removing the requirement that an applicant must be authorized to treat personnel enlisted in the United States armed services. The bill limits the practice under the license to no more 30 days per calendar year and provides there is no annual registration fee for this type of license.

The bill authorizes the North Carolina Medical Board to issue a "retired limited volunteer license" to applicants who have allowed his or her license in this or another state to practice medicine to become inactive, provided the physician:

- Practices only in clinics that specialize in the treatment of indigent patients.
- Does not receive compensation for services rendered.
- Complies with continuing medical education requirements and other rules adopted by the Board
- Pays a \$25 annual registration fee.

The bill provides that it is a Class 3 misdemeanor for a retired limited volunteer licensee to practice medicine at places other than clinics that specialize in the treatment of indigent patients.

This is consistent with the penalty for unauthorized practice under the limited volunteer license.

The Proposed Committee Substitute limits the liability of non-profit community health referral services for the acts and omissions of the physician the low income patient was referred to by the service provided the service maintains appropriate liability insurance.

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

S743-SMSQ-27(CSSQ-26) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 743

Short Title: Encourage Volunteer Health Care Providers.

(Public)

Sponsors: Senator Goolsby.

Referred to: Health Care.

April 20, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ENCOURAGE THE PROVISION OF MEDICAL SERVICES TO INDIGENT
3 PERSONS BY PROVIDING FOR A RETIRED LIMITED VOLUNTEER LICENSE AND
4 BY BROADENING THE APPLICABILITY OF A LIMITED VOLUNTEER LICENSE.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. G.S. 90-12.1A reads as rewritten:

7 "§ 90-12.1A. Limited volunteer license.

8 (a) The Board may issue a "military limited volunteer license" to an applicant who:

9 (1) Has a license to practice medicine and surgery in another state; state; and

10 (2) Produces a letter from the state of licensure indicating the applicant is
11 applicant's license is active and in good standing; and standing.

12 (3) Is authorized to treat personnel enlisted in a branch of the United States
13 armed services or veterans.

14 (b) The Board may issue a "retired limited volunteer license" to an applicant who is a
15 retired physician and has allowed his or her license to practice medicine and surgery in this
16 State or another state to become inactive.

17 (c) A physician holding a limited license under this section shall comply with the
18 continuing medical education requirements pursuant to rules adopted by the Board.

19 (d) The Board shall issue a limited license under this section within 30 days after an
20 applicant provides the Board with information satisfying the requirements of this section.

21 (e) The holder of a limited license under this section may practice medicine and surgery
22 only at clinics that specialize in the treatment of indigent patients. The holder of the limited
23 license may not receive compensation for services rendered at clinics specializing in the care of
24 indigent patients.

25 (e1) The holder of a limited volunteer license shall practice medicine and surgery within
26 this State for no more than 30 days per calendar year.

27 (f) The holder of a limited license issued pursuant to this section who practices
28 medicine or surgery at places other than clinics that specialize in the treatment of indigent
29 patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less
30 than twenty-five dollars (\$25.00) nor more than fifty dollars (\$50.00) for each offense. The
31 Board, in its discretion, may revoke the limited license after due notice is given to the holder of
32 the limited license.

33 (g) The Board may, by rule, require an applicant for a limited license under this section
34 to comply with other requirements or submit additional information the Board deems
35 appropriate."

36 SECTION 2. Article 1 of Chapter 90 of the General Statutes is amended by adding
37 a new section to read:



1 **"§ 90-12.1B. Retired limited volunteer license.**

2 (a) The Board may issue a "retired limited volunteer license" to an applicant who is a
3 physician and who has allowed his or her license to practice medicine and surgery in this State
4 or another state to become inactive.

5 (b) A physician holding a limited license under this section shall comply with the
6 continuing medical education requirements pursuant to rules adopted by the Board.

7 (c) The holder of a limited license under this section may practice medicine and surgery
8 only at clinics that specialize in the treatment of indigent patients. The holder of the limited
9 license may not receive compensation for services rendered at clinics specializing in the care of
10 indigent patients.

11 (d) The Board shall issue a limited license under this section within 30 days after an
12 applicant provides the Board with information satisfying the requirements of this section.

13 (e) The holder of a limited license issued pursuant to this section who practices
14 medicine or surgery at places other than clinics that specialize in the treatment of indigent
15 patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined not less
16 than twenty-five dollars (\$25.00) nor more than fifty dollars (\$50.00) for each offense. The
17 Board, in its discretion, may revoke the limited license after due notice is given to the holder of
18 the limited license.

19 (f) The Board may, by rule, require an applicant for a limited license under this section
20 to comply with other requirements or submit additional information the Board deems
21 appropriate."

22 **SECTION 3. G.S. 90-13.1 reads as rewritten:**

23 **"§ 90-13.1. License fees.**

24 (a) Each applicant for a license to practice medicine and surgery in this State under
25 either G.S. 90-9.1 or G.S. 90-9.2 shall pay to the North Carolina Medical Board an application
26 fee of three hundred fifty dollars (\$350.00).

27 (b) Each applicant for a limited license to practice in a medical education and training
28 program under G.S. 90-12.01 shall pay to the Board a fee of one hundred dollars (\$100.00).

29 (c) An applicant for a limited volunteer license under G.S. 90-12.1A or G.S. 90-12.1B
30 shall not pay a fee.

31 (d) A fee of twenty-five dollars (\$25.00) shall be paid for the issuance of a duplicate
32 license.

33 (e) All fees shall be paid in advance to the North Carolina Medical Board, to be held in
34 a fund for the use of the Board.

35 (f) For the initial and annual licensure of an anesthesiologist assistant, the Board may
36 require the payment of a fee not to exceed one hundred fifty dollars (\$150.00)."

37 **SECTION 4. G.S. 90-13.2 reads as rewritten:**

38 **"§ 90-13.2. Registration every year with Board.**

39 (a) Every person licensed to practice medicine by the North Carolina Medical Board
40 shall register annually with the Board within 30 days of the person's birthday.

41 (b) A person who registers with the Board shall report to the Board the person's name
42 and office and residence address and any other information required by the Board, and shall
43 pay an annual registration fee of one hundred seventy-five dollars (\$175.00), except those who
44 have a limited license to practice in a medical education and training program approved by the
45 Board for the purpose of education or training shall pay a registration fee of one hundred
46 twenty-five dollars (~~\$125.00~~) and (~~\$125.00~~), those who have a retired limited volunteer license
47 pursuant to G.S. 90-12.1B shall pay an annual registration fee of twenty-five dollars (~~\$25.00~~).
48 (~~\$25.00~~), and those who have a limited volunteer license pursuant to G.S. 90-12.1A shall pay
49 no annual registration fee. However, licensees who have a limited license to practice for the
50 purpose of education and training under G.S. 90-12.01 shall not be required to pay more than
51 one annual registration fee for each year of training.

1 (c) A physician who is not actively engaged in the practice of medicine in North
2 Carolina and who does not wish to register the license may direct the Board to place the license
3 on inactive status.

4 (d) A physician who is not actively engaged in the practice of medicine in North
5 Carolina and who does not wish to register the license may direct the Board to place the license
6 on inactive status.

7 (e) A physician who fails to register as required by this section shall pay an additional
8 fee of fifty dollars (\$50.00) to the Board. The license of any physician who fails to register and
9 who remains unregistered for a period of 30 days after certified notice of the failure is
10 automatically inactive. The Board shall retain jurisdiction over the holder of the inactive
11 license.

12 (f) Except as provided in ~~G.S. 90-12.1A~~, G.S. 90-12.1B, a person whose license is
13 inactive shall not practice medicine in North Carolina nor be required to pay the annual
14 registration fee.

15 (g) Upon payment of all accumulated fees and penalties, the license of the physician
16 may be reinstated, subject to the Board requiring the physician to appear before the Board for
17 an interview and to comply with other licensing requirements. The penalty may not exceed the
18 maximum fee for a license under G.S. 90-13.1."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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HOUSE BILL 160
Second Edition Engrossed 4/28/11

Short Title: Check-Off Donation: Breast Cancer Screening. (Public)

Sponsors: Representatives Dollar, Justice, Howard, and Stevens (Primary Sponsors).
For a complete list of Sponsors, see Bill Information on the NCGA Web Site.

Referred to: Health and Human Services, if favorable, Finance.

February 23, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO PROVIDE SPACE ON THE INCOME TAX RETURN FOR INDIVIDUALS TO
3 MAKE DONATIONS FOR EARLY DETECTION OF BREAST AND CERVICAL
4 CANCER AS PROVIDED BY THE BREAST AND CERVICAL CANCER CONTROL
5 PROGRAM.

6 The General Assembly of North Carolina enacts:

7 SECTION 1. Article 9 of Chapter 105 of the General Statutes is amended by
8 adding a new section to read:

9 **"§ 105-269.7. Contribution by individual for early detection of breast and cervical cancer.**

10 An individual entitled to a refund of income taxes under Part 2 of Article 4 of this Chapter
11 may elect to contribute all or part of the refund to be used for early detection of breast and
12 cervical cancer at the Cancer Prevention and Control Branch of the Division of Public Health
13 of the Department of Health and Human Services. The Secretary shall provide appropriate
14 language and space on the individual income tax form in which to make the election. The
15 Secretary shall include in the income tax instructions an explanation that the contributions will
16 be used for early detection of breast and cervical cancer only. The election becomes irrevocable
17 upon filing the individual's income tax return for the taxable year.

18 The Secretary shall transmit the contributions made pursuant to this section to the State
19 Treasurer to be distributed for early detection of breast and cervical cancer. The State Treasurer
20 shall distribute the contributions to the Cancer Prevention and Control Branch of the Division
21 of Public Health of the Department of Health and Human Services. Funds distributed pursuant
22 to this section shall be used only for early detection of breast and cervical cancer and shall be
23 used in accordance with North Carolina's Breast and Cervical Cancer Control Program's
24 policies and procedures."

25 SECTION 2. The General Assembly finds that the funds generated by this act are
26 intended to be additional funding for early detection of breast and cervical cancer and are not
27 intended to replace current appropriations for early detection of breast and cervical cancer.

28 SECTION 3. This act is effective for taxable years beginning on or after January 1,
29 2011 and expires for tax years beginning on or after January 1, 2015.





HOUSE BILL 160: Check-Off Donation: Breast Cancer Screening

2011-2012 General Assembly

Committee:	Senate Health Care	Date:	May 17, 2011
Introduced by:	Reps. Dollar, Justice, Howard, Stevens	Prepared by:	Theresa Matula
Analysis of:	Second Edition		Committee Staff

SUMMARY: *House Bill 160 requires the Secretary of the Department of Revenue to provide taxpayers an opportunity on the individual income tax form to elect to contribute all or part of an income tax refund for the early detection of breast and cervical cancer through the Cancer Prevention and Control Branch of the Division of Public Health, Department of Health and Human Services.*

BILL ANALYSIS: House Bill 160 would amend Article 9, Chapter 105, adding G.S. 105-269.7, to allow an individual to contribute an income tax refund to be used for early detection of breast and cervical cancer. The election is irrevocable once the tax return is filed. The bill would require the Secretary of the Department of Revenue to:

- Provide appropriate language and space on the individual income tax form;
- Include in the income tax instructions an explanation that the contributions will be used for early detection of breast and cervical cancer only; and
- Transmit the contributions to the State Treasurer who will distribute the contributions to the Cancer Prevention and Control Branch, Division of Public Health, Department of Health and Human Services to be used for early detection of breast and cervical cancer in accordance with North Carolina's Breast and Cervical Cancer Control Program's (NC BCCCP) policies and procedures.

Section 2 of the bill provides that the intent of the bill is to provide additional funding for early detection of breast and cervical cancer and not to replace current appropriations for this purpose.

EFFECTIVE DATE: House Bill 160 would become effective for taxable years beginning on or after January 1, 2011 and expire for tax years beginning on or after January 1, 2015.

BACKGROUND:

Check-off programs allow taxpayers to "check-off" a contribution to a state program on a personal income tax form. According to the Federal Tax Administration (FTA), check-off programs began in 1972 with the federal government allowing taxpayers to designate \$1 of their liability to a special presidential campaign fund. Check-off programs in states have increased in popularity. According to the FTA, 2002 state income tax returns identified 220 check-off programs available in 41 states and the District of Columbia. Preserving non-game wildlife is the most common check-off, other popular programs include: political campaigns, child abuse and neglect prevention, and breast/cervical cancer research and prevention. Currently in North Carolina, taxpayer's may apply a refund of income taxes to a future estimated tax liability (G.S. 105-269.4) and may contribute a refund to the Wildlife Conservation Account (G.S. 105-269.5) to be used for wildlife management, protection and preservation.

The North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) provides free or low-cost breast and cervical cancer screenings and follow-up to eligible women. The services are offered at some community health centers, hospitals and private physicians' offices and at most local health

House Bill 160

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departments. NC BCCCP provides services to North Carolina women who meet the following requirements:

- are uninsured or underinsured;
- are without Medicare Part B or Medicaid;
- are between ages 40 - 64 for breast screening services and 18 - 64 for cervical screening services; &
- have a household income at or below 250% of the federal poverty level.

Breast and Cervical Cancer: The following information was provided by the Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC):

- *Breast cancer* is the most commonly diagnosed cancer among women in the United States, after skin cancer,¹ and the second most common cause of cancer death, after lung cancer, among U.S. women.¹ In 2005, 186,467 women were diagnosed with breast cancer and 41,116 women died from the disease.¹ Based on recent estimates, more than \$8.4 billion per year (in 2004 dollars) is spent in the United States on the treatment of breast cancer.²

Mammography is the best available method to detect breast cancer in its earliest, most treatable form. Studies show that early detection of breast cancer can save lives. Mammography, performed every 1 to 2 years for women aged 40 years or older, can reduce mortality by approximately 20% – 25% over 10 years.

- *Cervical cancer* was once the leading cause of death for women in the United States. However, during the past 50 years, incidence (the number of new cases each year) and mortality (the number of deaths each year) from cervical cancer have declined 75%, largely because of the widespread use of the Papanicolaou (Pap) test to detect cervical abnormalities.³ In 2005, 11,999 women were diagnosed with cervical cancer and 3,924 women died from the disease.¹

Cervical cancer is highly preventable if precancerous changes are identified and it is highly treatable if cancer is detected early. Regular Pap tests decrease a woman's risk of developing cervical cancer by detecting precancerous cervical lesions, which can be treated effectively.³ The U.S. Preventive Services Task Force currently recommends a Pap test at least every 3 years, beginning within 3 years of onset of sexual activity or at age 21, whichever comes first.

*Shawn Parker and Greg Roney contributed to this summary.
H160-SMSH-76(e2) v6*

¹U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999–2005 Incidence and Mortality Web-based Report*. Atlanta, GA: Department of Health and Human Services, Centers for Disease Control and Prevention; Washington, DC: National Cancer Institute; 2009. Available at www.cdc.gov/uscs.

²National Cancer Institute. *Cancer Trends Progress Report—2007 Update*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health. Available at <http://progressreport.cancer.gov>. In 2004 dollars, based on methods described in *Medical Care* 2002; 40 (8 Suppl):IV-104–117.

³National Institutes of Health. *Cervical Cancer. NIH Consensus Statement*. 1996;14(1):1–38.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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D

SENATE BILL 496*
PROPOSED COMMITTEE SUBSTITUTE S496-CSSQ-32 [v.6]

5/17/2011 5:24:19 PM

Short Title: Medicaid and Health Choice Provider Req. (Public)

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED
AN ACT RELATING TO REQUIREMENTS OF MEDICAID AND HEALTH CHOICE
PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 108C.

"Medicaid and Health Choice Provider Requirements.

"§ 108C-1. Scope; applicability of this Chapter.

This Chapter applies to providers enrolled in Medicaid or Health Choice.

"§ 108C-2. Definitions.

The following definitions apply in this Chapter:

- (1) Adverse determination. – A final decision by the Department to deny, terminate, suspend, reduce or recoup a Medicaid payment or to deny, terminate, or suspend a provider's or applicant's participation in the Medical Assistance Program.
- (2) Applicant. – An individual, partnership, group, association, corporation, institution, or entity that applies to the Department for enrollment as a provider in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children.
- (3) Department. – The North Carolina Department of Health and Human Services, its legally authorized agents, contractors, or vendors who acting within the scope of their authorized activities, assess, authorize, manage, review, audit, monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance Program for Children, or any waivers of the federal Medicaid Act granted by United States Department of Health and Human Services.
- (4) Division. – The Division of Medical Assistance of the Department.
- (5) Final overpayment, assessment, or fine. – The amount the provider owes after appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court, provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.



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- 1 (6) Health Choice. – The Health Insurance Program for Children authorized by
2 G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the
3 Health Insurance Program for Children.
4 (7) Managing employee. – A general manager, business manager, administrator,
5 director, or other individual who exercises operational or managerial control
6 over, or who directly or indirectly conducts the day to day operation of, an
7 institution, organization, or agency. Managing employee also includes the
8 chief financial officer for the organization.
9 (8) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54
10 and as set forth in the North Carolina State Plan of Medical Assistance.
11 (9) Owner and/or operator. – A person or corporation that has direct, indirect or
12 combined ownership interest in a health care provider greater than or equal
13 to five percent 5%, or is a partner, officer, or director of a health care
14 provider organized as a partnership, corporation, or limited liability
15 company.
16 (10) Provider. – An individual, partnership, group, association, corporation,
17 institution, or entity required to enroll in the North Carolina Medical
18 Assistance Program or the North Carolina Health Insurance Program for
19 Children to provide services, goods, supplies, or merchandise to a Medicaid
20 or Health Choice recipient.
21 (11) Revalidation. – The reenrollment of a provider in the Medicaid or Health
22 Choice programs as required under federal law.

23 **"§ 108C-3. Medicaid and Health Choice provider screening.**

24 (a) Provider Screening. – The Department shall conduct provider screening of Medicaid
25 and Health Choice providers in accordance with applicable State or federal law or regulation.

26 (b) Enrollment Screening. – The Department must screen all initial provider
27 applications for enrollment in Medicaid and Health Choice, including applications for a new
28 practice location, and all revalidation requests based on Department assessment of risk and
29 assignment of the provider to a categorical risk level of "limited," "moderate," or "high." If a
30 provider could fit within more than one risk level described in this section, the highest level of
31 screening is applicable.

32 (c) Limited Categorical Risk Provider Types. – The following provider types are hereby
33 designated as "limited" categorical risk:

- 34 (1) Ambulatory surgical centers.
35 (2) End-stage renal disease facilities.
36 (3) Federally qualified health centers.
37 (4) Health programs operated by an Indian Health Program (as defined in
38 section 4(12) of the Indian Health Care Improvement Act) or an urban
39 Indian organization (as defined in section 4(29) of the Indian Health Care
40 Improvement Act) that receives funding from the Indian Health Service
41 pursuant to Title V of the Indian Health Care Improvement Act.
42 (5) Histocompatibility laboratories.
43 (6) Hospitals, including critical access hospitals, Department of Veterans Affairs
44 Hospitals, and other State or federally owned hospital facilities.
45 (7) Local Education Agencies.
46 (8) Mammography screening centers.
47 (9) Mass immunization roster billers.
48 (10) Nursing facilities, including Intermediate Care Facilities for the Mentally
49 Retarded.
50 (11) Organ procurement organizations.

1 (12) Physician or nonphysician practitioners (including nurse practitioners,
2 CRNAs, physician assistants, physician extenders, occupational therapists,
3 speech/language pathologists, chiropractors, and audiologists), optometrists
4 and medical groups or clinics.

5 (13) Radiation therapy centers.

6 (14) Rural health clinics.

7 (15) Hearing aid dealers.

8 (d) Limited Screening Level: Screening Requirements. – When the Department
9 designates a provider or supplier as a "limited" categorical level of risk, the Department shall do
10 all of the following:

11 (1) Conduct database checks on a pre-enrollment and post-enrollment basis to
12 ensure that providers and suppliers continue to meet the enrollment criteria
13 for their provider/supplier type.

14 (2) Conduct license verifications, including licensure verifications across state
15 lines for physicians or nonphysician practitioners and providers and
16 suppliers that obtain or maintain Medicare or Medicaid billing privileges as
17 a result of state licensure, including state licensure in states other than North
18 Carolina.

19 (3) Verify that a provider or supplier meets all applicable federal regulations and
20 State requirements for the provider or supplier type prior to making an
21 enrollment determination.

22 (e) Moderate Categorical Risk Provider Types. – The following provider types are
23 hereby designated as "moderate" categorical risk:

24 (1) Ambulance services.

25 (2) Comprehensive outpatient rehabilitation facilities.

26 (3) Critical Access Behavioral Health Agencies.

27 (4) Dentists and orthodontists.

28 (5) Hospice organizations.

29 (6) Independent clinical laboratories.

30 (7) Independent diagnostic testing facilities.

31 (8) Pharmacy Services.

32 (9) Physical therapists enrolling as individuals or as group practices.

33 (10) Revalidating adult care homes delivering Medicaid-reimbursed services.

34 (11) Revalidating agencies providing durable medical equipment, including, but
35 not limited to, orthotics and prosthetics.

36 (12) Revalidating agencies providing home or community-based services
37 pursuant to waivers authorized by the federal Centers for Medicare and
38 Medicaid Services under 42 U.S.C. § 1396n(c).

39 (13) Revalidating agencies providing private duty nursing, home health, or home
40 infusion.

41 (f) Moderate Screening Level: Screening Requirements. – When the Department
42 designates a provider or supplier as a "moderate" categorical level of risk, the Department shall
43 do all of the following:

44 (1) Conduct a pre-enrollment and post-enrollment site visit. The purpose of the
45 site visit will be to verify that the information submitted to the Department is
46 accurate and to determine compliance with federal and State enrollment
47 requirements.

48 (2) Perform all of the "limited" screening requirements described in subsection
49 (d) of this section.

50 (g) High Categorical Risk Provider Types. – The following provider types are hereby
51 designated as "high" categorical risk:

- 1 (1) Prospective (newly enrolling) adult care homes delivering
2 Medicaid-reimbursed services.
- 3 (2) Agencies providing behavioral health services, excluding Critical Access
4 Behavioral Health Agencies.
- 5 (3) Directly enrolled outpatient behavioral health services providers.
- 6 (4) Prospective (newly enrolling) agencies providing durable medical
7 equipment, including, but not limited to, orthotics and prosthetics.
- 8 (5) Agencies providing HIV case management.
- 9 (6) Prospective (newly enrolling) agencies providing home or community-based
10 services pursuant to waivers authorized by the federal Centers for Medicare
11 and Medicaid Services under 42 U.S.C. § 1396n(c).
- 12 (7) Agencies providing personal care services or in-home care services.
- 13 (8) Prospective (newly enrolling) agencies providing private duty nursing, home
14 health, home infusion.
- 15 (9) Providers against whom the Department has imposed a payment suspension
16 based upon a credible allegation of fraud in accordance with 42 C.F.R. §
17 455.23 within the previous 12-month period. The Department shall return
18 the provider to its original risk category not later than 12 months after the
19 cessation of the payment suspension.
- 20 (10) Providers that were excluded, or whose owners, operators, or managing
21 employees were excluded, by the U.S. Department of Health and Human
22 Services Office of Inspector General or another state's Medicaid program
23 within the previous 10 years.
- 24 (11) Providers who have incurred a Medicaid or Health Choice final
25 overpayment, assessment, or fine to the Department in excess of twenty
26 percent (20%) of the provider's payments received from Medicaid and
27 Health Choice in the previous 12-month period. The Department shall return
28 the provider to its original risk category not later than 12 months after the
29 completion of the provider's repayment of the final overpayment,
30 assessment, or fine.
- 31 (12) Providers whose owners, operators, or managing employees were convicted
32 of a disqualifying offense pursuant to G.S. 108C-4 but were granted an
33 exemption by the Department within the previous 10 years.
- 34 (h) High Screening Level: Screening Requirements. – When the Department designates
35 a provider or supplier as a "high" categorical level of risk, the Department shall do all of the
36 following:
 - 37 (1) Conduct a fingerprint-based criminal history record check in accordance
38 with G.S. 108C-4.
 - 39 (2) Perform all of the "limited" and "moderate" screening requirements
40 described in subsections (d) and (f) of this section.
 - 41 (3) Require the submission of a set of fingerprints for a national background
42 check from all individuals who maintain a five percent (5%) or greater direct
43 or indirect ownership interest in the provider or supplier.
- 44 (i) For providers dually enrolled in the federal Medicare program and Medicaid, the
45 Department may rely on the results of the provider screening performed by Medicare
46 contractors.
- 47 (j) For out-of-state providers, the Department may rely on the results of the provider
48 screening performed by the Medicaid agencies or Health Insurance Program for Children
49 agencies of other states.
- 50 "§ 108C-4. Criminal history record checks for certain providers.

1 (a) The Department shall conduct criminal history records checks of provider applicants
2 and enrolled providers in accordance with federal law and regulation.

3 (b) The Division shall deny enrollment or terminate the enrollment of a provider where
4 any person with a five percent (5%) or greater direct or indirect ownership interest in the
5 provider has been convicted of a criminal offense related to that person's involvement with the
6 Medicare, Medicaid, or Health Choice program in the last 10 years, unless the Division
7 determines that denial or termination of enrollment is not in the best interests of Medicaid and
8 the State Medicaid agency documents that determination in writing. The Department shall
9 honor civil and criminal settlement agreements entered into with a provider or any person with
10 a five percent (5%) or greater direct or indirect ownership interest in the provider within 10
11 years of the effective date of this Act.

12 (c) The Division may deny enrollment or terminate the enrollment of a provider subject
13 to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator,
14 or employee if, after review of the seriousness, age, and other circumstances involving the
15 offense, the Division determines it is in the best interest of the integrity of Medicaid or Health
16 Choice to do so: any criminal offenses as set forth in any of the following Articles of Chapter
17 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article
18 5A, Endangering Executive, Legislative, and Court Officers; Article 6, Homicide; Article 7A,
19 Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction;
20 Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material;
21 Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article
22 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and
23 Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit
24 Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,
25 Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article
26 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery;
27 Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article
28 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the
29 Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes
30 also include possession or sale of drugs in violation of the North Carolina Controlled
31 Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses
32 such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in
33 violation of G.S. 20-138.1 through G.S. 20-138.5.

34 **"§ 108C-5. Payment suspension and audits utilizing extrapolation.**

35 (a) The Department may suspend payments to a provider in accordance with the
36 requirements and procedures set forth in 42 C.F.R. § 455.23.

37 (b) In addition to the procedures for suspending payment set forth at 42 C.F.R. §
38 455.23, the Department may also suspend payment to any provider that (1) owes a final
39 overpayment, assessment, or fine to the Department and has not entered into an approved
40 payment plan with the Department; or (2) has had its participation in the Medicaid or Health
41 Choice programs suspended or terminated by the Department. For purposes of this Section, a
42 suspension or termination of participation does not become final until all administrative appeal
43 rights have been exhausted and shall not include any agency decision that is being contested at
44 the Department or the Office of Administrative Hearings or in Superior Court provided that the
45 Superior Court has entered a stay pursuant to the provisions of G.S. § 150B-48.

46 (c) For providers who owe a final overpayment, assessment, or fine to the Department,
47 the payment suspension shall begin the thirty-first day after the overpayment, assessment, or
48 fine becomes final. The payment suspension shall not exceed the amount owed to the
49 Department, including any applicable penalty and interest charges.

1 (d) Providers whose participation in the Medicaid or Health Choice programs has been
2 suspended or terminated shall have all payments suspended beginning on the thirty-first day
3 after the suspension or termination becomes final.

4 (e) The Department shall consult with the N.C. Departments of Treasury and Revenue
5 and other State departments and agencies to determine if a provider owes debts or fines to the
6 State. The Department may collect any of these debts owed to the State subsequent to
7 consideration by the Department of the financial impact upon the provider and the impact upon
8 access to the services provided by the provider.

9 (f) When issuing payment suspensions in accordance with this Chapter, the Department
10 may suspend payment to all providers which share the same IRS Employee Identification
11 Number or corporate parent as the provider or provider site location which owes the final
12 overpayment, assessment, or fine. The Department shall give 30 days advance written notice to
13 all providers which share the same IRS Employee Identification Number or corporate parent as
14 the provider or provider site location of the intention of the Department to implement a
15 payment suspension.

16 (g) The Department is authorized to approve a payment plan for a provider to pay a
17 final overpayment, assessment, or fine including interest and any penalty. The payment plan
18 can include a term of up to 24 months. The Department shall establish in rule the conditions of
19 such provider payment plans. Nothing in this subsection shall prevent the provider and the
20 Department from mutually agreeing to modifications of a payment plan.

21 (h) All payments suspended in accordance with this Chapter shall be applied toward
22 any final overpayment, assessment, or fine owed to the Department.

23 (i) Prior to extrapolating the results of any audits, the Department shall demonstrate
24 and inform the provider that: 1) the provider failed to substantially comply with the
25 requirements of State or federal law or regulation or 2) the Department has credible allegation
26 of fraud concerning the provider.

27 (j) Audits that result in the extrapolation of results must be performed and reviewed by
28 individuals who shall be credentialed, as applicable, in the matters to be audited, including but
29 not limited to coding or specific clinical issues.

30 (k) Audits that result in the extrapolation of results must identify at the outset the
31 matters reviewed and specifically list the clinical (including but not limited to assessment of
32 medical necessity), coding, authorization or other matters reviewed and the time periods
33 reviewed

34 (l) For those matters and time periods identified in subsection (k) of this section, the
35 provider shall not be subject to further audits by the Department.

36 (m) The Department may specify in rules the means by which a provider may conduct
37 voluntary self-audits upon matters subject to audit by the Department. Upon the provider's
38 payment or payment agreement for any final overpayment, assessment, or fine arising from the
39 provider's self-audit, the provider shall not be subject to further audits by the Department of the
40 matters and time periods subject to the provider's self-audit.

41 (n) The results of audits that result in the extrapolation of results may be challenged by
42 a provider within the limited or moderate risk categories, pursuant to G.S. 108C-3, by: 1) the
43 provider conducting 100% file review of those matters and time periods identified in subsection
44 (k) of this section or 2) the provider conducting a second audit utilizing the same statistical and
45 sampling methodology as the Department to produce a sample twice the size of the original
46 sample to review those matters and time periods identified in subsection (k). The provider shall
47 have sixty days from the date of the receipt of the Department's notice of tentative audit
48 findings to complete the review chosen and provide the results to the Department. The results
49 of the review conducted by the provider shall be binding upon provider. Nothing in this
50 subsection shall limit a provider from challenging the statistical methodology of the

1 Department's original sample or the credentials of the individuals who performed and reviewed
2 the audit.

3 (o) The Department shall permit limited correction of clerical, typographical,
4 scrivener's, and computer errors by the provider prior to final determination of any audit.

5 (p) The provider shall have no less than thirty days from the date of the receipt of the
6 Department's notice of tentative audit findings to provide additional documentation not
7 provided to the Department during any audit.

8 (q) Except as required by federal law or regulation or instances of credible allegation of
9 fraud, the provider shall be subject to audits which result in the extrapolation of results for a
10 time period of up to 36 months from date of payment of the final overpayment, assessment, or
11 fine.

12 (r) At least annually, the Department shall publish notice of the intention to use audits
13 that result in the extrapolation of results upon its web site. Such notice shall include the
14 services, provider types, audit elements, and the time periods subject to audit.

15 **"§ 108C-6. Agents, clearinghouses, and alternate payees; registration required.**

16 The Department is authorized to establish a registry of billing agents, clearinghouses,
17 and/or alternate payees that submit claims on behalf of providers and to charge a fee to recover
18 the costs of maintaining the registry in accordance with the 42 U.S.C. §1396a(a)(79) and
19 implementing regulations. All billing agents, clearinghouses, or alternate payees shall register
20 with the Department before submitting claims on behalf of providers or within six months of
21 enactment of this Chapter, whichever is later. Any billing agent, clearinghouse, or alternate
22 payee that fails to register with the Department prior to submitting claims on behalf of
23 providers shall be excluded from the registry for a period not to exceed one year.

24 **"§ 108C-7. Prepayment claims review.**

25 (a) In order to ensure that claims presented by a provider for payment by the
26 Department meet the requirements of federal and State laws and regulations and medical
27 necessity criteria, a provider may be required to undergo prepayment claims review by the
28 Department. Grounds for being placed on prepayment claims review shall include, but shall not
29 be limited to, receipt by the Department of credible allegations of fraud, identification of
30 aberrant billing practices as a result of investigations or data analysis performed by the
31 Department or other grounds as defined by the Department in rule.

32 (b) Providers shall not be entitled to payment prior to claims review by the Department.
33 The Department shall notify the provider in writing of the decision and the process for
34 submitting claims for prepayment claims review no less than 20 calendar days prior to
35 instituting prepayment claims review. The notice shall contain the following:

36 (1) An explanation of the Department's decision to place the provider on
37 prepayment claims review.

38 (2) A description of the review process and claims processing times.

39 (3) A description of the claims subject to prepayment claims review.

40 (4) A specific list of all supporting documentation that the provider will need to
41 submit contemporaneously with the claims that will be subject to the
42 prepayment claims review.

43 (5) The process for submitting claims and supporting documentation.

44 (6) The standard of evaluation used by the Department to determine when a
45 provider's claims will no longer be subject to prepayment claims review.

46 (c) For any claims in which the Department has given prior authorization, prepayment
47 review shall not include review of the medical necessity for the approved services.

48 (d) The Department shall process all clean claims submitted for prepayment review
49 within 20 calendar days of submission by the provider. If the provider failed to provide any of
50 the specifically requested supporting documentation necessary to process a claim pursuant to
51 this section, the Department shall send to the provider written notification of the lacking or

deficient documentation within 15 calendar days of receipt of such claim. The Department shall have an additional 20 days to process a claim upon receipt of the documentation.

(e) The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum seventy percent (70%) clean claims rate. If the provider does not meet this standard within six months of being placed on prepayment claims review, the Department may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment review for an additional six-month period. The Department shall give adequate advance notice of any modification, suspension or termination of the Medicaid Administrative Participation Agreement. In no instance shall prepayment claims review continue longer than 12 months.

(f) The decision to place or maintain a provider on prepayment claims review does not constitute a contested case under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of the Department to place a provider on prepayment review.

"§ 108C-8. Threshold recovery amount.

The Department shall not pursue recovery of Medicaid or Health Choice overpayments owed to the State for any total amount less than one hundred fifty dollars (\$150.00) unless directed to do so by the Centers for Medicare and Medicaid Services or unless such recovery would be cost-effective and in the best interest of the State of North Carolina and Medicaid recipients.

"§ 108C-9. Provider enrollment criteria.

(a) Applicants who submit an initial application for enrollment in North Carolina Medicaid or North Carolina Health Choice, shall be required to submit an attestation and complete trainings prior to being enrolled.

(b) The applicant's attestation shall contain a statement that the applicant's organization has met the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance programs, does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission, does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other State Medicaid or Children's Health Insurance program, and has implemented a corporate compliance program as required under federal law. The Department shall set forth by rule the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance Program.

(c) Prior to being initially enrolled in the North Carolina Medicaid or Health Choice programs, an applicant's representative shall attend trainings as designated by the Department in rules, including but not limited to the following:

- (1) The Basic Medicaid Billing Guide, common billing errors, and how to avoid them.
- (2) Audit procedures, including explanation of the process by which the Department extrapolates audit results.
- (3) How to identify Medicaid recipient fraud.
- (4) How to report suspected fraud or abuse.
- (5) Medicaid recipient due process and appeal rights.

Online training shall be available for completion through the Department's website. The Department may charge a fee to recover costs of such trainings.

(d) Making any materially false or misleading statement in an attestation or enrollment application shall be grounds for denial, termination of, or permanent exclusion from enrollment in the North Carolina Medicaid or North Carolina Health Choice programs.

(e) The approval or acceptance of a Medicaid administrative participation or enrollment agreement by the Department that grants Medicaid billing privileges or allows a provider to furnish services under the North Carolina State Plan for Medical Assistance in accordance with 42 C.F.R. §431.107 requires compliance by the provider and the Department with the terms of the Medicaid administrative participation or enrollment agreement.

"§ 108C-10. Change of ownership and successor liability.

(a) For providers subject to this Chapter, any of the following occurrences shall constitute a change of ownership:

(1) In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by Chapter 59 of the General Statutes.

(2) In the case of a Limited Liability Company (LLC), the withdrawal or removal of a member, or when a person acquires a membership interest from the LLC or when a business entity converts or merges into the LLC pursuant to Chapter 57A of the General Statutes.

(3) In the case of an unincorporated sole proprietorship, the transfer of title and property of the provider that constitute the provider's business of providing services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient to another party.

(4) The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. Transfer of corporate stock or the merger of another corporation into the provider corporation shall not constitute change of ownership. Merger of related provider corporations shall not constitute a change in ownership.

(5) The lease of all or part of a provider's facility that will continue to be utilized for the provision of services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient shall constitute a change of ownership of the leased portion.

(b) A provider must notify the Department at least 30 calendar days prior to the effective date of any change of ownership.

(c) An assigned Medicaid administrative participation or enrollment agreement shall be subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, both of the following:

(1) Any existing plan of correction.

(2) Payment of any outstanding final overpayments, assessments, or fines owed to the Department.

(d) The Department shall not as a condition of enrollment require a provider to accept an assigned Medicaid administrative participation or enrollment agreement upon a change in ownership.

"§ 108C-11. Cooperation with investigations and audits.

(a) Providers shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department. Providers who fail to grant prompt and reasonable access or who fail to timely provide specifically designated documentation to the Department may be terminated from the North Carolina Medicaid or North Carolina Health Choice programs.

(b) The Department shall make all attempts to examine documentation without interfering with the clinical activities of the provider while conducting activities on the provider's premises.

(c) Nothing in this Chapter shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health

and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

"§ 108C-12. Appeals by Medicaid Providers and Applicants.

(a) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid provider or applicant to appeal an adverse determination made by the Department.

(b) Appeals. – Except as provided by this section a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes.

(c) Final Decision. – The Office of Administrative Hearing shall make a final decision within 180 days of the date of filing of the appeal with the Office of Administrative Hearings. The time to make a final decision shall be extended in the event of delays caused or requested by the Department.

(d) Burden of Proof. – The Department shall have the burden of proof in appeals of Medicaid providers or applicants concerning an adverse determination."

SECTION 2. G.S. 108A-54.2 reads as rewritten"

"§ 108A-54.2. Procedures for changing medical policy.

(a) The Department shall adopt rules to develop, amend, and adopt medical coverage policy in accordance with ~~the following:~~this section.

(b) Medical coverage policy is defined as those policies, definitions, or guidelines utilized to evaluate, treat or support the health or developmental conditions of a recipient so as to determine eligibility, authorization or continued authorization, medical necessity, course of treatment and supports, and clinical supports treatment practices for a covered procedure, product or service.

(1) During the development of new medical coverage policy or amendment to existing medical coverage policy, consult with and seek the advice of the Physician Advisory Group and other organizations the Secretary deems appropriate. The Secretary shall also consult with and seek the advice of officials of the professional societies or associations representing providers who are affected by the new medical coverage policy or amendments to existing medical coverage policy.

(2) At least 45 days prior to the adoption of new or amended medical coverage policy, the Department shall:

- a. Publish the proposed new or amended medical coverage policy on the Department's Web site;
- b. Notify all Medicaid providers of the proposed, new, or amended medical coverage policy; and
- c. Upon request, provide persons copies of the proposed medical coverage policy.

(3) During the 45-day period immediately following publication of the proposed new or amended medical coverage policy, accept oral and written comments on the proposed new or amended policy.

(4) If, following the comment period, the proposed new or amended medical coverage policy is modified, then the Department shall, at least 15 days prior to its adoption:

- a. Notify all Medicaid providers of the proposed policy;
- b. Upon request, provide persons notice of amendments to the proposed policy; and
- c. Accept additional oral or written comments during this 15-day period.

1 **SECTION 3.** G.S. 150B-1(d)(9) reads as rewritten:

2 "(9) The Department of Health and Human Services in adopting new or
3 amending existing medical coverage policies under the State Medicaid
4 ~~Program.~~ Program pursuant to G.S. 108A-54.2."

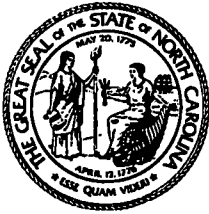
5 **SECTION 4.** G.S. 150B-1(e) reads as rewritten:

6 " (e) Exemptions From Contested Case Provisions. – The contested case provisions of
7 this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter.
8 The contested case provisions of this Chapter do not apply to the following:

9 ...
10 (16) ~~The Department of Health and Human Services with respect to contested~~
11 ~~eases commenced by (i) Medicaid providers appealing a denial or reduction~~
12 ~~in reimbursement for community support services, and (ii) community~~
13 ~~support services providers appealing decisions by the LME to deny or~~
14 ~~withdraw the provider's endorsement.~~

15 (17) The Department of Health and Human Services with respect to the review of
16 North Carolina Health Choice Program determinations regarding delay,
17 denial, reduction, suspension, or termination of health services, in whole or
18 in part, including a determination about type or level of services."

19 **SECTION 5.** G.S. 108C-5 as enacted by Section 1 of this act is effective when the
20 bill becomes law and applies to audits instituted on or after that date and to final overpayments,
21 assessments, or fines due on or after that date. G.S. 108C-6 as enacted by Section 1 of this act
22 becomes effective January 1, 2012. Section 2 of this act becomes effective October 1, 2011 and
23 applies to medical coverage policies new or amended on or after that date. The remainder of the
24 act is effective when it becomes law.



SENATE BILL 496: Medicaid and Health Choice Provider Req.

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Pate
Analysis of: PCS to First Edition
S496-CSSQ-32

Date: May 31, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS for Senate Bill 496 creates Medicaid and Health Choice provider requirements for enrollment or re-enrollment in the Medicaid or Children's Health Choice Programs. The PCS also creates various regulations related to audits of providers under Medicaid or Health Choice.*

BILL ANALYSIS:

Section 1: Adds a new Chapter to the General Statutes: Chapter 108C. Medicaid and Health Choice Provider Requirements.

108C-1: indicates that this Chapter applies to all providers enrolled in Medicaid and North Carolina Health Choice.

108C-2: Creates a definitions section.

108C-3: Outlines the provider screening requirements and categorical risk provider types as required by federal law.

108C-4: Requires criminal history records checks for all provider applicants and enrolled providers in accordance with the federal law. This section outlines what offenses will result in, or have the potential to result in, a provider enrollment denial or termination.

108C-5: Gives the Department of Health and Human Services (the Department) the authority to suspend payments to providers pursuant to the federal law, as well as any provider who owes a final overpayment, assessment, or fine to the Department but has not entered into a payment plan with the Department or any provider who has had its participation in Medicaid or Health Choice suspended or terminated. This section also authorizes audits and outlines ways in which the results of the audits may be challenged. This section also addresses provider self-audits.

108C-6: Authorizes the Department to establish a registry of billing agents, clearinghouses, and alternate payees that submit claims on behalf of providers as required by federal law.

108C-7: Outlines a process for requiring a provider to undergo prepayment claims review should there exist grounds for such a requirement.

108C-8: Directs that the Department shall not pursue a recovery of Medicaid or Health Choice overpayments for any total less than \$150.00 unless directed to do so by CMS or if it would be cost-effective or in the best interests of the State.

108C-9: Creates criteria for new applicants for provider enrollment in Medicaid or Health Choice. Providers are required to submit an attestation that the provider does not owe any final overpayments, assessments, or fines to Medicaid or Health Choice in North Carolina or any other state and is compliant with federal law. New applicants must also attend trainings to be designated by the Department regarding Medicaid billing and fraud.

Senate PCS 496

Page 2

108C-10: States that the Department shall not, as a condition of enrollment, require a provider to accept an assigned Medicaid administrative participation or enrollment agreement upon a change in ownership. This section outlines the occurrences that constitute a change in ownership.

108C-11: Requires providers to cooperate with all site visits, audits, investigations, post-payment reviews, or other program integrity requirements conducted by the Department.

108C-12: Outlines an appeals process for enrolled providers and provider applications under this Chapter.

Section 2: Makes a technical change to G.S. 105B-1(d)(9).

Section 3: Removes the Department with respect to contested cases commenced by Medicaid providers appealing a denial or reduction in reimbursement for community support services or commenced by community support services providers appealing decisions by the LME to deny or withdraw the provider's endorsement from the listed exemptions from contested cases provisions under the Administrative Procedures Act.

EFFECTIVE DATE: G.S. 108C-5 is effective when the bill becomes law and applies to audits instituted on or after that date and to final overpayments, assessments, or fines due on or after that date. G.S. 108C-6 becomes effective January 1, 2012. Section 2 becomes effective October 1, 2011, and applies to new medical coverage policies or policies amended on or after that date. The remainder of the act is effective when it becomes law.

S496-SMTK-30(CSSQ-32) v6

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 496*

Short Title: PPACA/Required Fraud and Abuse Provisions.

(Public)

Sponsors: Senator Pate.

Referred to: Health Care.

April 4, 2011

A BILL TO BE ENTITLED
AN ACT TO PROVIDE FRAUD AND ABUSE PROVISIONS REQUIRED BY THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 108C.

"Medicaid and Health Choice Provider Requirements.

"§ 108C-1. Scope; applicability of this Chapter.

This Chapter applies to providers enrolled in Medicaid or Health Choice.

"§ 108C-2. Definitions.

The following definitions apply in this Chapter:

- (1) Affordable Care Act. – The Patient Protection and Affordable Care Act, Public Law 111-148.
- (2) Applicant. – An individual, partnership, group, association, corporation, institution, or entity that applies to the Department for enrollment as a provider in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children.
- (3) Department. – The North Carolina Department of Health and Human Services, its agents, contractors, or vendors who assess, authorize, manage, review, audit, monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance Program for Children, or any waivers of the federal Medicaid Act granted by United States Department of Health and Human Services.
- (4) Division. – The Division of Medical Assistance of the Department.
- (5) Final overpayment, assessment, or fine. – The amount the provider owes after all appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in superior court, provided that the superior court has entered a stay pursuant to the provisions of G.S. 150B-48.
- (6) Health Choice. – The Health Insurance Program for Children authorized by G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.
- (7) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54 and as set forth in the North Carolina State Plan of Medical Assistance.



* 5 4 9 6 - V - 1 *

- 1 (8) Payment suspension. – Any delay or withholding of payment to a provider
2 by the Department.
- 3 (9) Provider. – An individual, partnership, group, association, corporation,
4 institution, or entity required to enroll in the North Carolina Medical
5 Assistance Program or the North Carolina Health Insurance Program for
6 Children that provides services, goods, supplies, or merchandise to a
7 Medicaid or Health Choice recipient.
- 8 (10) Revalidation. – The reenrollment of a provider in the Medicaid or Health
9 Choice programs as required under federal law.

10 **"§ 108C-3. Medicaid and Health Choice provider screening.**

11 (a) Provider Screening. – The Department shall conduct provider screening of Medicaid
12 and Health Choice providers in accordance with the Affordable Care Act, implementing
13 regulations and this section.

14 (b) Enrollment Screening. – The Department must screen all initial applications for
15 enrollment in Medicaid and Health Choice, including applications for a new practice location,
16 and any response to a revalidation request based on Department assessment of risk and
17 assignment to a categorical risk level of "limited," "moderate," or "high." If a provider could fit
18 within more than one risk level described in this section, the highest level of screening is
19 applicable.

20 (c) Limited Categorical Risk Provider Categories. – The following provider types are
21 hereby designated as "limited" categorical risk:

- 22 (1) Ambulatory surgical centers.
- 23 (2) End-stage renal disease facilities.
- 24 (3) Federally qualified health centers.
- 25 (4) Health programs operated by an Indian Health Program (as defined in
26 section 4(12) of the Indian Health Care Improvement Act) or an urban
27 Indian organization (as defined in section 4(29) of the Indian Health Care
28 Improvement Act) that receives funding from the Indian Health Service
29 pursuant to Title V of the Indian Health Care Improvement Act.
- 30 (5) Histocompatibility laboratories.
- 31 (6) Hospitals, including critical access hospitals, Department of Veterans Affairs
32 Hospitals, and other State or federally owned hospital facilities.
- 33 (7) Local Education Agencies.
- 34 (8) Mammography screening centers.
- 35 (9) Mass immunization roster billers.
- 36 (10) Nursing facilities, including Intermediate Care Facilities for the Mentally
37 Retarded.
- 38 (11) Organ procurement organizations.
- 39 (12) Physician or nonphysician practitioners (including nurse practitioners,
40 CRNAs, physician assistants, physician extenders, occupational therapists,
41 speech/language pathologists, directly enrolled outpatient behavioral health
42 services providers, chiropractors, and audiologists) and medical groups or
43 clinics.
- 44 (13) Radiation therapy centers.
- 45 (14) Rural health clinics.
- 46 (15) Transplants and Transplant-Related Services.
- 47 (16) Vision and Hearing Aid providers.

48 (d) Limited Screening Level: Screening Requirements. – When the Department
49 designates a provider or supplier as a "limited" categorical level of risk, the Department does all
50 of the following:

- (1) Conducts database checks on a preenrollment and postenrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.
- (2) Conducts license verifications, including licensure verifications across state lines for physicians or nonphysician practitioners and providers and suppliers that obtain or maintain Medicare or Medicaid billing privileges as a result of state licensure, including state licensure in states other than North Carolina.
- (3) Verifies that a provider or supplier meets all applicable federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination.
- (e) Moderate Categorical Risk Provider Categories. – The following provider types are hereby designated as "moderate" categorical risk:

 - (1) Ambulance services.
 - (2) Comprehensive outpatient rehabilitation facilities.
 - (3) Critical Access Behavioral Health Agencies.
 - (4) Dentists and orthodontists.
 - (5) Hospice organizations.
 - (6) Independent clinical laboratories.
 - (7) Independent diagnostic testing facilities.
 - (8) Pharmacy Services.
 - (9) Physical therapists enrolling as individuals or as group practices.
 - (10) Revalidating Adult Care Homes delivering Medicaid-reimbursed services.
 - (11) Revalidating Agencies Providing Behavioral Health Services, excluding Critical Access Behavioral Health Agencies and directly enrolled outpatient behavioral health services providers.
 - (12) Revalidating Agencies Providing Durable Medical Equipment, including, but not limited to, Orthotics and Prosthetics.
 - (13) Revalidating Agencies Providing HIV Case Management.
 - (14) Revalidating Agencies Providing Home- or Community-Based Services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
 - (15) Revalidating Agencies Providing Private Duty Nursing, Home Health, Home Infusion, Personal Care Services, or In-Home Care Services.
- (f) Moderate Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "moderate" categorical level of risk, the Department does all of the following:

 - (1) Conducts a preenrollment and postenrollment site visit. The purpose of the site visit will be to verify that the information submitted to the Department is accurate and to determine compliance with federal and State enrollment requirements.
 - (2) Performs the "limited" screening requirements described in subsection (d) of this section.
- (g) High Categorical Risk Provider Categories. – The following provider types are hereby designated as "high" categorical risk:

 - (1) Prospective (newly enrolling) Adult Care Homes delivering Medicaid-reimbursed services.
 - (2) Prospective (newly enrolling) Agencies Providing Behavioral Health Services, excluding Critical Access Behavioral Health Agencies and directly enrolled outpatient behavioral health services providers.

- (3) Prospective (newly enrolling) Agencies Providing Durable Medical Equipment, including, but not limited to, Orthotics and Prosthetics.
- (4) Prospective (newly enrolling) Agencies Providing HIV Case Management.
- (5) Prospective (newly enrolling) Agencies Providing Home-or Community-Based Services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
- (6) Prospective (newly enrolling) Agencies Providing Private Duty Nursing, Home Health, Home Infusion, Personal Care Services, or In-Home Care Services.
- (7) Providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period.
- (8) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the OIG or another state's Medicaid program within the previous 10 years.
- (9) Providers who have incurred a Medicaid or Health Choice final overpayment to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid and Health Choice in the previous 12-month period.
- (10) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-4 but were granted an exemption by the Department within the previous 10 years.
- (h) High Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "high" categorical level of risk, the Department does all of the following:
- (1) Conducts a fingerprint-based criminal history record check in accordance with G.S. 108C-4.
- (2) Performs the "limited" and "moderate" screening requirements described in subsections (d) and (f) of this section.
- (3) Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a five percent (5%) or greater direct or indirect ownership interest in the provider or supplier.
- (i) For providers dually enrolled in the federal Medicare program and Medicaid, the Department may rely on the results of the provider screening performed by Medicare contractors.
- (j) For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Health Insurance Program for Children agencies of other states.
- (k) The Department must verify that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state.
- (l) The Department must confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
- (m) The Department must revalidate the enrollment of all providers, regardless of provider type, at least every five years.
- (n) Any enrolled provider must permit the Centers for Medicare and Medicaid Services (CMS), its agents, its designated contractors, or the Department to conduct unannounced on-site inspections of any and all provider locations.
- § 108C-4. Criminal history record checks for certain providers.**
- (a) For purposes of this section the following definitions apply:
- (1) A "managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency. Managing employee also includes the chief financial officer for the organization.

(2) An "owner and/or operator" means a person or corporation that:

- a. Has a combination of direct and indirect ownership interests equal to five percent (5%) or more in a health care provider;
- b. Has an indirect ownership interest equal to five percent (5%) or more in a health care provider;
- c. Has an ownership interest totaling five percent (5%) or more in a health care provider;
- d. Is a partner in a health care provider that is organized as a partnership; or
- e. Is an officer or director of a health care provider that is organized as a corporation or limited liability company.

(b) The Division shall conduct a criminal history record check of and require the submission of fingerprints from a provider subject to G.S. 108C-3(g) (a high categorical risk provider), an owner and/or operator of that provider, and its managing employees, unless it is relying upon the results of screenings pursuant to G.S. 108C-3(i) or G.S. 108C-3(j). The Division may also require a criminal history record check of employees involved in direct patient care on behalf of the high categorical risk provider.

(c) Upon request by the Division, the North Carolina Department of Justice shall provide to the Division a national criminal history for a provider or other person subject to this section. The Division shall provide to the Department of Justice the fingerprints of the covered person to be checked, any additional information required by the Department of Justice, and a form signed by the person to be checked consenting to the check of the criminal history record and to the use of fingerprints and other identifying information required by the State or National Repositories. The fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Division shall keep all information pursuant to this section confidential. The Department of Justice shall charge a reasonable fee for conducting the checks of the criminal history records authorized by this section.

(c) All releases of criminal history information under this section shall be subject to, and in compliance with, rules governing the dissemination of criminal history record checks as adopted by the North Carolina Division of Criminal Information. All of the information received through the checking of the criminal history record is privileged information and for the exclusive use of the Division.

(d) The Division shall deny enrollment or terminate the enrollment of a provider where any person with a five percent (5%) or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Health Choice program in the last 10 years, unless the Division determines that denial or termination of enrollment is not in the best interests of Medicaid and the State Medicaid agency documents that determination in writing.

(e) The Division may deny enrollment or terminate the enrollment of a provider subject to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator, or employee if, after review of the seriousness, age, and other circumstances involving the offense, the Division determines it is in the best interest of the integrity of Medicaid or Health Choice to do so: any criminal offenses as 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,

1 Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14,
2 Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16,
3 Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and
4 Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit
5 Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,
6 Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article
7 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery;
8 Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article
9 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the
10 Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes
11 also include possession or sale of drugs in violation of the North Carolina Controlled
12 Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses
13 such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in
14 violation of G.S. 20-138.1 through G.S. 20-138.5.

15 **"§ 108C-5. Payment suspension.**

16 The Department may suspend payments of a Medicaid provider in accordance with the
17 requirements and procedures set forth in 42 C.F.R. § 455.23.

18 **"§ 108C-6. Agents, clearinghouses, and alternate payees; registration required.**

19 The Division shall require any agent, clearinghouse, or alternate payee that submits claims
20 to Medicaid or Health Choice on behalf of health care providers to register with the State
21 pursuant to section 6503 of the Affordable Care Act and implementing federal regulations. The
22 Division shall require no additional obligation or information from any agent, clearinghouse, or
23 alternate payee than is necessary to comply with federal law."

24 **SECTION 2.** The Division of Medical Assistance of the Department of Health and
25 Human Services, in consultation with stakeholder groups and the North Carolina Department of
26 Justice, may study the status of criminal history record and other employment background
27 checks among all providers and health care licensing boards and may make recommendations
28 to the General Assembly when it reconvenes its 2011 Regular Session in 2012 concerning the
29 use of background checks with respect to participation in the Medicaid and Health Choice
30 programs.

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

VISITOR REGISTRATION SHEET

Committee on Health Care

5/18/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

John Rinschen
Stam Ikon

NC Peds Society

NC Peds

Karen Brent

NC Peds Society

Maia C Monge

NC Peds Society

Nigar Hasanaliev

visitor

Julie Alexander

Citizen, FNP - Apex NC

Leah Elliott

intern

Erlynn Hawthorne

NCAP; NCALIA

Ashley Branham

NCAP

Betsy Vetter

Amer Hunt & Son

Tarelle A. Rhyme

Cape Fear Health Net

VISITOR REGISTRATION SHEET

Committee on Health Care

5/18/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Scott Winsant	Cape Fear HealthNet / New Hanover Regional Medical Ctr
Marcus Jimison	N.C. Medical Board
Thomas Mansfield	N.C. Medical Board.
Debbie Adams	DHHS
Fred Eckel	NCAP
Morgan Noms	NCAP
MACARY MARGINIAK	NCAP
OUTA DAVIS	KROGER
Holly West	DHHS
Michael Tink	NCACC
Rob Pritchett	NC BOARD OF PHARMACY
Laura Gould	NC Health and Wellness Trust Fund

VISITOR REGISTRATION SHEET

Committee on Health Care

5/18/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Symmetti Inc	NCAHDO
Silvia Harris	Durham Co Health Dept.
John Perrin	Governor's Office
Jon Carr	Jordan Price Law Firm
Greg Griggs	NCAFP
Amey Whitel	NC Medical Society
Brent Hazlett	NCAFP
Brian Forrest	NCAFP
Steve Sancier	NC Grassroots
Jill Mon	UNC SOG
Tommy Tarrell	Richmond Co Health Dept

VISITOR REGISTRATION SHEET

Committee on Health Care

Name of Committee

5/18/11

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kristi Huff	NCHCFA
W Shuehl	NCA and SOC
DAVID BARNES	PS
Maeu OK	Smith Anderson
W. Graham Culm	DLC & Assoc
Mari Wildin	Novant
Gretchen Kelly	FHC
Mathew McNamee	Carolinas Health Care Sys.
Allison Waller	Nelson Mullins
Jeff North	OHHS OHSR

VISITOR REGISTRATION SHEET

Committee on Health Care

5/18/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carolyn Moser	Madison Co. Health Dept 493 Medical Park Drive Marshall, NC 28753
Virginia Annunzio	HARRVILL ASSOC.
Beth Lovette	Wilkes County Health Director 300 College St Wilkesboro, NC 28697
Kelley McNabb	NC Nurses Association 103 Enterprise St Raleigh, NC 27607
Tina Gordon	NC Nurses
Jane Harris	NCNA
Joanne Stevens	NCNA / Stevens Inc.
Steve Mitchell	APUS
JOEL MANNARD	CPA: ADOL / NCAPP
Fred Bann	Bann: Asso.

MINUTES

SENATE HEALTH CARE COMMITTEE

Thursday, June 2, 2011, 2:00 p.m.

Room 1124, LOB

The Senate Committee on Health Care met at 2:00 p.m. on Thursday, June 2, 2011, in Room 1124 of the Legislative Building. Fifteen members were present with Senator Harris Blake presiding.

Senator Blake called the meeting to order, welcomed everyone and introduced the Sergeants-at-Arms: Chester White, Steve Wilson and Bob Myrick. He then introduced the Pages assisting with the meeting: David Scoggins, Charlotte Yarboro, Abby Newsom, Holland Robinson, Raj Singh and Ross Byrd.

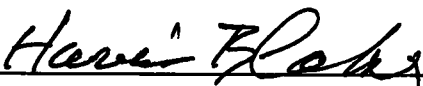
Senator Blake recognized Senator Pate to explain the Committee Substitute for SB 496, "PPACA/Required fraud and Abuse Provisions." After the explanation, Senator Bingham moved for a Favorable Report to the PCS with Unfavorable to the Original Bill. The motion carried.

SB 552, "Regional Public Health Authority Pilot" was explained by Senator Hartsell. Senator Rucho made a motion for a Favorable Report to the PCS, Unfavorable to the Original Bill. The motion passed.

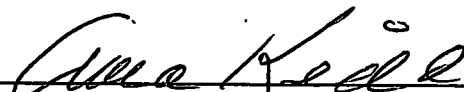
SB 617, "LRC Study Food Allergy & Anaphylaxis Management," was next to be explained by Senator Atwater. Senator Allran moved for a Favorable Report to the PCS with Unfavorable to the Original Bill; the motion carried.

SB 655, "Dentistry Management Arrangements," was the last bill to come before the Committee. After Senators Pate and Allran explained the bill, two members of the audience were given an opportunity to express their views concerning the bill. Afterwards, Senator Rucho assured the Committee he would address any concerns they had concerning certain aspects of the bill. With that in mind, Senator Mansfield made a motion for a Favorable Report; the motion carried.

Having heard all bills on the agenda, Senator Blake adjourned the meeting at 3:10 p.m.



Senator Harris Blake, Co-Chair



Anna Kidd, Committee Assistant

Anna Kidd (Sen. Blake)

From: Joyce Hodge (Senate LA Director)
it: Wednesday, June 01, 2011 5:42 PM
@SenateCommitteeNotice
ject: <NCGA> Senate Health Care Committee Meeting Notice for Thu, 06-02-2011 at 15 Minutes After Session - CORRECTED

Principal Clerk _____

Reading Clerk _____

Corrected: TIME CHANGE 15 MINUTES AFTER SESSION

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
Thursday	June 2, 2011	15 Minutes After Session	1124 LB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 496	PPACA/Required Fraud and Abuse Provisions.	Senator Pate
SB 552	Regional Public Health Authority Pilot.	Senator Hartsell
SB 617	LRC Study Food Allergy & Anaphylaxis Mgmt.	Senator Atwater
SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell
SB 655	Dentistry Management Arrangements.	Senator Allran Senator Pate

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee

Thursday, June 2, 2011, 15 minutes After Session

Room 1124

AGENDA

Welcome and Opening Remarks

Introduction of Pages

BILLS

SB 496	PPACA/Required Fraud and Abuse Provisions.	Senate Pate
SB 552	Regional Public Health Authority Pilot.	Senator Hartsell
SB 617	LRC Study Food Allergy & Anaphylaxis Mgmt.	Senator Atwater
SB 246	Expand Pharmacists' Immunizing Authority.	Senator Hartsell
SB 655	Dentistry Management Arrangements.	Senator Allran

Other Business

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 496*

Short Title: PPACA/Required Fraud and Abuse Provisions.

(Public)

Sponsors: Senator Pate.

Referred to: Health Care.

April 4, 2011

A BILL TO BE ENTITLED
AN ACT TO PROVIDE FRAUD AND ABUSE PROVISIONS REQUIRED BY THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 108C.

"Medicaid and Health Choice Provider Requirements.

"§ 108C-1. Scope; applicability of this Chapter.

This Chapter applies to providers enrolled in Medicaid or Health Choice.

"§ 108C-2. Definitions.

The following definitions apply in this Chapter:

- (1) Affordable Care Act. – The Patient Protection and Affordable Care Act, Public Law 111-148.
- (2) Applicant. – An individual, partnership, group, association, corporation, institution, or entity that applies to the Department for enrollment as a provider in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children.
- (3) Department. – The North Carolina Department of Health and Human Services, its agents, contractors, or vendors who assess, authorize, manage, review, audit, monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance Program for Children, or any waivers of the federal Medicaid Act granted by United States Department of Health and Human Services.
- (4) Division. – The Division of Medical Assistance of the Department.
- (5) Final overpayment, assessment, or fine. – The amount the provider owes after all appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in superior court, provided that the superior court has entered a stay pursuant to the provisions of G.S. 150B-48.
- (6) Health Choice. – The Health Insurance Program for Children authorized by G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.
- (7) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54 and as set forth in the North Carolina State Plan of Medical Assistance.



- (8) Payment suspension. – Any delay or withholding of payment to a provider by the Department.
- (9) Provider. – An individual, partnership, group, association, corporation, institution, or entity required to enroll in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children that provides services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient.
- (10) Revalidation. – The reenrollment of a provider in the Medicaid or Health Choice programs as required under federal law.

"§ 108C-3. Medicaid and Health Choice provider screening.

(a) Provider Screening. – The Department shall conduct provider screening of Medicaid and Health Choice providers in accordance with the Affordable Care Act, implementing regulations and this section.

(b) Enrollment Screening. – The Department must screen all initial applications for enrollment in Medicaid and Health Choice, including applications for a new practice location, and any response to a revalidation request based on Department assessment of risk and assignment to a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(c) Limited Categorical Risk Provider Categories. – The following provider types are hereby designated as "limited" categorical risk:

- (1) Ambulatory surgical centers.
- (2) End-stage renal disease facilities.
- (3) Federally qualified health centers.
- (4) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.
- (5) Histocompatibility laboratories.
- (6) Hospitals, including critical access hospitals, Department of Veterans Affairs Hospitals, and other State or federally owned hospital facilities.
- (7) Local Education Agencies.
- (8) Mammography screening centers.
- (9) Mass immunization roster billers.
- (10) Nursing facilities, including Intermediate Care Facilities for the Mentally Retarded.
- (11) Organ procurement organizations.
- (12) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, directly enrolled outpatient behavioral health services providers, chiropractors, and audiologists) and medical groups or clinics.
- (13) Radiation therapy centers.
- (14) Rural health clinics.
- (15) Transplants and Transplant-Related Services.
- (16) Vision and Hearing Aid providers.

(d) Limited Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "limited" categorical level of risk, the Department does all of the following:

- (1) Conducts database checks on a preenrollment and postenrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.
- (2) Conducts license verifications, including licensure verifications across state lines for physicians or nonphysician practitioners and providers and suppliers that obtain or maintain Medicare or Medicaid billing privileges as a result of state licensure, including state licensure in states other than North Carolina.
- (3) Verifies that a provider or supplier meets all applicable federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination.

(e) Moderate Categorical Risk Provider Categories. – The following provider types are hereby designated as "moderate" categorical risk:

- (1) Ambulance services.
- (2) Comprehensive outpatient rehabilitation facilities.
- (3) Critical Access Behavioral Health Agencies.
- (4) Dentists and orthodontists.
- (5) Hospice organizations.
- (6) Independent clinical laboratories.
- (7) Independent diagnostic testing facilities.
- (8) Pharmacy Services.
- (9) Physical therapists enrolling as individuals or as group practices.
- (10) Revalidating Adult Care Homes delivering Medicaid-reimbursed services.
- (11) Revalidating Agencies Providing Behavioral Health Services, excluding Critical Access Behavioral Health Agencies and directly enrolled outpatient behavioral health services providers.
- (12) Revalidating Agencies Providing Durable Medical Equipment, including, but not limited to, Orthotics and Prosthetics.
- (13) Revalidating Agencies Providing HIV Case Management.
- (14) Revalidating Agencies Providing Home- or Community-Based Services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
- (15) Revalidating Agencies Providing Private Duty Nursing, Home Health, Home Infusion, Personal Care Services, or In-Home Care Services.

(f) Moderate Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "moderate" categorical level of risk, the Department does all of the following:

- (1) Conducts a preenrollment and postenrollment site visit. The purpose of the site visit will be to verify that the information submitted to the Department is accurate and to determine compliance with federal and State enrollment requirements.
- (2) Performs the "limited" screening requirements described in subsection (d) of this section.

(g) High Categorical Risk Provider Categories. – The following provider types are hereby designated as "high" categorical risk:

- (1) Prospective (newly enrolling) Adult Care Homes delivering Medicaid-reimbursed services.
- (2) Prospective (newly enrolling) Agencies Providing Behavioral Health Services, excluding Critical Access Behavioral Health Agencies and directly enrolled outpatient behavioral health services providers.

- (3) Prospective (newly enrolling) Agencies Providing Durable Medical Equipment, including, but not limited to, Orthotics and Prosthetics.
- (4) Prospective (newly enrolling) Agencies Providing HIV Case Management.
- (5) Prospective (newly enrolling) Agencies Providing Home-or Community-Based Services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
- (6) Prospective (newly enrolling) Agencies Providing Private Duty Nursing, Home Health, Home Infusion, Personal Care Services, or In-Home Care Services.
- (7) Providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period.
- (8) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the OIG or another state's Medicaid program within the previous 10 years.
- (9) Providers who have incurred a Medicaid or Health Choice final overpayment to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid and Health Choice in the previous 12-month period.
- (10) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-4 but were granted an exemption by the Department within the previous 10 years.
- (h) High Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "high" categorical level of risk, the Department does all of the following:
- (1) Conducts a fingerprint-based criminal history record check in accordance with G.S. 108C-4.
- (2) Performs the "limited" and "moderate" screening requirements described in subsections (d) and (f) of this section.
- (3) Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a five percent (5%) or greater direct or indirect ownership interest in the provider or supplier.
- (i) For providers dually enrolled in the federal Medicare program and Medicaid, the Department may rely on the results of the provider screening performed by Medicare contractors.
- (j) For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Health Insurance Program for Children agencies of other states.
- (k) The Department must verify that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state.
- (l) The Department must confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
- (m) The Department must revalidate the enrollment of all providers, regardless of provider type, at least every five years.
- (n) Any enrolled provider must permit the Centers for Medicare and Medicaid Services (CMS), its agents, its designated contractors, or the Department to conduct unannounced on-site inspections of any and all provider locations.
- § 108C-4. Criminal history record checks for certain providers.**
- (a) For purposes of this section the following definitions apply:
- (1) A "managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency. Managing employee also includes the chief financial officer for the organization.

(2) An "owner and/or operator" means a person or corporation that:

- a. Has a combination of direct and indirect ownership interests equal to five percent (5%) or more in a health care provider;
- b. Has an indirect ownership interest equal to five percent (5%) or more in a health care provider;
- c. Has an ownership interest totaling five percent (5%) or more in a health care provider;
- d. Is a partner in a health care provider that is organized as a partnership; or
- e. Is an officer or director of a health care provider that is organized as a corporation or limited liability company.

(b) The Division shall conduct a criminal history record check of and require the submission of fingerprints from a provider subject to G.S. 108C-3(g) (a high categorical risk provider), an owner and/or operator of that provider, and its managing employees, unless it is relying upon the results of screenings pursuant to G.S. 108C-3(i) or G.S. 108C-3(j). The Division may also require a criminal history record check of employees involved in direct patient care on behalf of the high categorical risk provider.

(c) Upon request by the Division, the North Carolina Department of Justice shall provide to the Division a national criminal history for a provider or other person subject to this section. The Division shall provide to the Department of Justice the fingerprints of the covered person to be checked, any additional information required by the Department of Justice, and a form signed by the person to be checked consenting to the check of the criminal history record and to the use of fingerprints and other identifying information required by the State or National Repositories. The fingerprints of the individual shall be forwarded to the State Bureau of Investigation for a search of the State criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Division shall keep all information pursuant to this section confidential. The Department of Justice shall charge a reasonable fee for conducting the checks of the criminal history records authorized by this section.

(c) All releases of criminal history information under this section shall be subject to, and in compliance with, rules governing the dissemination of criminal history record checks as adopted by the North Carolina Division of Criminal Information. All of the information received through the checking of the criminal history record is privileged information and for the exclusive use of the Division.

(d) The Division shall deny enrollment or terminate the enrollment of a provider where any person with a five percent (5%) or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Health Choice program in the last 10 years, unless the Division determines that denial or termination of enrollment is not in the best interests of Medicaid and the State Medicaid agency documents that determination in writing.

(e) The Division may deny enrollment or terminate the enrollment of a provider subject to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator, or employee if, after review of the seriousness, age, and other circumstances involving the offense, the Division determines it is in the best interest of the integrity of Medicaid or Health Choice to do so: any criminal offenses as 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,

1 Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14,
2 Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16,
3 Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and
4 Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit
5 Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,
6 Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article
7 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery;
8 Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article
9 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the
10 Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes
11 also include possession or sale of drugs in violation of the North Carolina Controlled
12 Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses
13 such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in
14 violation of G.S. 20-138.1 through G.S. 20-138.5.

15 **"§ 108C-5. Payment suspension.**

16 The Department may suspend payments of a Medicaid provider in accordance with the
17 requirements and procedures set forth in 42 C.F.R. § 455.23.

18 **"§ 108C-6. Agents, clearinghouses, and alternate payees; registration required.**

19 The Division shall require any agent, clearinghouse, or alternate payee that submits claims
20 to Medicaid or Health Choice on behalf of health care providers to register with the State
21 pursuant to section 6503 of the Affordable Care Act and implementing federal regulations. The
22 Division shall require no additional obligation or information from any agent, clearinghouse, or
23 alternate payee than is necessary to comply with federal law."

24 **SECTION 2.** The Division of Medical Assistance of the Department of Health and
25 Human Services, in consultation with stakeholder groups and the North Carolina Department of
26 Justice, may study the status of criminal history record and other employment background
27 checks among all providers and health care licensing boards and may make recommendations
28 to the General Assembly when it reconvenes its 2011 Regular Session in 2012 concerning the
29 use of background checks with respect to participation in the Medicaid and Health Choice
30 programs.

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



SENATE BILL 496: Medicaid and Health Choice Provider Req.

2011-2012 General Assembly

Committee:	Senate Health Care	Date:	May 17, 2011
Introduced by:	Sen. Pate	Prepared by:	Amy Jo Johnson
Analysis of:	PCS to First Edition S496-CSSQ-32		Committee Counsel

SUMMARY: *The PCS for Senate Bill 496 creates Medicaid and Health Choice provider requirements for enrollment or re-enrollment in the Medicaid or Children's Health Choice Programs. The PCS also creates various regulations related to audits of providers under Medicaid or Health Choice.*

BILL ANALYSIS:

Section 1: Adds a new Chapter to the General Statutes: Chapter 108C. Medicaid and Health Choice Provider Requirements.

108C-1: indicates that this Chapter applies to all providers enrolled in Medicaid and North Carolina Health Choice.

108C-2: Creates a definitions section.

108C-3: Outlines the provider screening requirements and categorical risk provider types as required by federal law.

108C-4: Requires criminal history records checks for all provider applicants and enrolled providers in accordance with the federal law. This section outlines what offenses will result in, or have the potential to result in, a provider enrollment denial or termination.

108C-5: Gives the Department of Health and Human Services (the Department) the authority to suspend payments to providers under the federal law, as well as any provider who owes a final overpayment, assessment, or fine to the Department but has not entered into a payment plan with the Department or any provider who has had its participation in Medicaid or Health Choice suspended or terminated. This section also authorizes audits. The Department is able to use the audit to extrapolate results if it is able to inform the provider and demonstrate that the provider failed to substantially comply with State or federal law or regulations or that the Department has a credible allegation of fraud concerning the provider. This section outlines ways in which the results of the audits may be challenged.

108C-6: Authorizes the Department to establish a registry of billing agents, clearinghouses, and alternate payees that submit claims on behalf of providers. All billing agents, clearinghouses, and alternate payees must register with the Department. If they do not, the billing agent, clearinghouse or alternate payee shall be excluded from the registry for up to one year.

108C-7: Outlines a process for requiring a provider to undergo prepayment claims review should there exist grounds for such a requirement.

108C-8: Directs that the Department shall not pursue a recovery of Medicaid or Health Choice overpayments for any total less than \$150.00 unless directed to do so by CMS or if it would be cost-effective or in the best interests of the State.

Senate PCS 496

Page 2

108C-9: Creates criteria for new applicants for provider enrollment in Medicaid or Health Choice. Providers are required to submit an attestation that the provider does not own any final overpayments, assessments, or fines to Medicaid or Health Choice in North Carolina or any other state and is compliant with federal law. New applicants must also attend trainings to be designated by the Department regarding Medicaid billing and fraud.

108C-10: States that the Department shall not, as a condition of enrollment, require a provider to accept an assigned Medicaid administrative participation or enrollment agreement upon a change in ownership. This section outlines the occurrences that constitute a change in ownership.

108C-11: Requires providers to cooperate with all site visits, audits, investigations, post-payment reviews, or other program integrity requirements conducted by the Department.

108C-12: Outlines an appeals process for enrolled providers and provider applications under this Chapter.

Section 2: Defines "medical coverage policy" and makes technical changes to G.S. 108A-54.2.

Section 3: Makes a technical change to G.S. 105B-1(d)(9).

Section 4: Removes the Department with respect to contested cases commenced by Medicaid providers appealing a denial or reduction in reimbursement for community support services or commenced by community support services providers appealing decisions by the LME to deny or withdraw the provider's endorsement from the listed exemptions from contested cases provisions under the Administrative Procedures Act.

EFFECTIVE DATE: G.S. 108-C is effective when the bill becomes law and applies to audits instituted on or after that date and to final overpayments, assessments, or fines due on or after that date. G.S. 108C-6 becomes effective January 1, 2012. Section 2 becomes effective October 1, 2011, and applies to medical coverage policies new or amended on or after that date. The remainder of the act is effective when it becomes law.

S496-SMTK-30(CSSQ-32) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 496*
PROPOSED COMMITTEE SUBSTITUTE S496-CSSQ-32 [v.8]

6/1/2011 3:41:32 PM

Short Title: Medicaid and Health Choice Provider Req.

(Public)

Sponsors:

Referred to:

April 4, 2011

A BILL TO BE ENTITLED
AN ACT RELATING TO REQUIREMENTS OF MEDICAID AND HEALTH CHOICE
PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 108C.

"Medicaid and Health Choice Provider Requirements.

"§ 108C-1. Scope; applicability of this Chapter.

This Chapter applies to providers enrolled in Medicaid or Health Choice.

"§ 108C-2. Definitions.

The following definitions apply in this Chapter:

- (1) Adverse determination. – A final decision by the Department to deny, terminate, suspend, reduce or recoup a Medicaid payment or to deny, terminate, or suspend a provider's or applicant's participation in the Medical Assistance Program.
- (2) Applicant. – An individual, partnership, group, association, corporation, institution, or entity that applies to the Department for enrollment as a provider in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children.
- (3) Department. – The North Carolina Department of Health and Human Services, its legally authorized agents, contractors, or vendors who acting within the scope of their authorized activities, assess, authorize, manage, review, audit, monitor, or provide services pursuant to Title XIX or XXI of the Social Security Act, the North Carolina State Plan of Medical Assistance, the North Carolina State Plan of the Health Insurance Program for Children, or any waivers of the federal Medicaid Act granted by United States Department of Health and Human Services.
- (4) Division. – The Division of Medical Assistance of the Department.
- (5) Final overpayment, assessment, or fine. – The amount the provider owes after appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court, provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.



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- (6) Health Choice. – The Health Insurance Program for Children authorized by G.S. 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.
- (7) Managing employee. – A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operation of, an institution, organization, or agency. Managing employee also includes the chief financial officer for the organization.
- (8) Medicaid. – The Medical Assistance program authorized by G.S. 108A-54 and as set forth in the North Carolina State Plan of Medical Assistance.
- (9) Owner and/or operator. – A person or corporation that has direct, indirect or combined ownership interest in a health care provider greater than or equal to five percent 5%, or is a partner, officer, or director of a health care provider organized as a partnership, corporation, or limited liability company.
- (10) Provider. – An individual, partnership, group, association, corporation, institution, or entity required to enroll in the North Carolina Medical Assistance Program or the North Carolina Health Insurance Program for Children to provide services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient.
- (11) Revalidation. – The reenrollment of a provider in the Medicaid or Health Choice programs as required under federal law.

"§ 108C-3. Medicaid and Health Choice provider screening.

(a) Provider Screening. – The Department shall conduct provider screening of Medicaid and Health Choice providers in accordance with applicable State or federal law or regulation.

(b) Enrollment Screening. – The Department must screen all initial provider applications for enrollment in Medicaid and Health Choice, including applications for a new practice location, and all revalidation requests based on Department assessment of risk and assignment of the provider to a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(c) Limited Categorical Risk Provider Types. – The following provider types are hereby designated as "limited" categorical risk:

- (1) Ambulatory surgical centers.
- (2) End-stage renal disease facilities.
- (3) Federally qualified health centers.
- (4) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.
- (5) Histocompatibility laboratories.
- (6) Hospitals, including critical access hospitals, Department of Veterans Affairs Hospitals, and other State or federally owned hospital facilities.
- (7) Local Education Agencies.
- (8) Mammography screening centers.
- (9) Mass immunization roster billers.
- (10) Nursing facilities, including Intermediate Care Facilities for the Mentally Retarded.
- (11) Organ procurement organizations.

(12) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, and audiologists), optometrists and medical groups or clinics.

(13) Radiation therapy centers.

(14) Rural health clinics.

(15) Hearing aid dealers.

(d) Limited Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "limited" categorical level of risk, the Department shall do all of the following:

(1) Conduct database checks on a pre-enrollment and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

(2) Conduct license verifications, including licensure verifications across state lines for physicians or nonphysician practitioners and providers and suppliers that obtain or maintain Medicare or Medicaid billing privileges as a result of state licensure, including state licensure in states other than North Carolina.

(3) Verify that a provider or supplier meets all applicable federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination.

(e) Moderate Categorical Risk Provider Types. – The following provider types are hereby designated as "moderate" categorical risk:

(1) Ambulance services.

(2) Comprehensive outpatient rehabilitation facilities.

(3) Critical Access Behavioral Health Agencies.

(4) Dentists and orthodontists.

(5) Hospice organizations.

(6) Independent clinical laboratories.

(7) Independent diagnostic testing facilities.

(8) Pharmacy Services.

(9) Physical therapists enrolling as individuals or as group practices.

(10) Revalidating adult care homes delivering Medicaid-reimbursed services.

(11) Revalidating agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.

(12) Revalidating agencies providing home or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).

(13) Revalidating agencies providing private duty nursing, home health, or home infusion.

(f) Moderate Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "moderate" categorical level of risk, the Department shall do all of the following:

(1) Conduct a pre-enrollment and post-enrollment site visit. The purpose of the site visit will be to verify that the information submitted to the Department is accurate and to determine compliance with federal and State enrollment requirements.

(2) Perform all of the "limited" screening requirements described in subsection (d) of this section.

(g) High Categorical Risk Provider Types. – The following provider types are hereby designated as "high" categorical risk:

- (1) Prospective (newly enrolling) adult care homes delivering Medicaid-reimbursed services.
 - (2) Agencies providing behavioral health services, excluding Critical Access Behavioral Health Agencies.
 - (3) Directly enrolled outpatient behavioral health services providers.
 - (4) Prospective (newly enrolling) agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.
 - (5) Agencies providing HIV case management.
 - (6) Prospective (newly enrolling) agencies providing home or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).
 - (7) Agencies providing personal care services or in-home care services.
 - (8) Prospective (newly enrolling) agencies providing private duty nursing, home health, home infusion.
 - (9) Providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the cessation of the payment suspension.
 - (10) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General or another state's Medicaid program within the previous 10 years.
 - (11) Providers who have incurred a Medicaid or Health Choice final overpayment, assessment, or fine to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid and Health Choice in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine.
 - (12) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-4 but were granted an exemption by the Department within the previous 10 years.
- (h) High Screening Level: Screening Requirements. – When the Department designates a provider or supplier as a "high" categorical level of risk, the Department shall do all of the following:
- (1) Conduct a fingerprint-based criminal history record check in accordance with G.S. 108C-4.
 - (2) Perform all of the "limited" and "moderate" screening requirements described in subsections (d) and (f) of this section.
 - (3) Require the submission of a set of fingerprints for a national background check from all individuals who maintain a five percent (5%) or greater direct or indirect ownership interest in the provider or supplier.
- (i) For providers dually enrolled in the federal Medicare program and Medicaid, the Department may rely on the results of the provider screening performed by Medicare contractors.
- (j) For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Health Insurance Program for Children agencies of other states.
- § 108C-4. Criminal history record checks for certain providers.**

1 (a) The Department shall conduct criminal history records checks of provider applicants
2 and enrolled providers in accordance with federal law and regulation.

3 (b) The Division shall deny enrollment or terminate the enrollment of a provider where
4 any person with a five percent (5%) or greater direct or indirect ownership interest in the
5 provider has been convicted of a criminal offense related to that person's involvement with the
6 Medicare, Medicaid, or Health Choice program in the last 10 years, unless the Division
7 determines that denial or termination of enrollment is not in the best interests of Medicaid and
8 the State Medicaid agency documents that determination in writing. The Department shall
9 honor civil and criminal settlement agreements entered into with a provider or any person with
10 a five percent (5%) or greater direct or indirect ownership interest in the provider within 10
11 years of the effective date of this Act.

12 (c) The Division may deny enrollment or terminate the enrollment of a provider subject
13 to G.S. 108C-3(g) for any of the following offenses of the provider, an owner and/or operator,
14 or employee if, after review of the seriousness, age, and other circumstances involving the
15 offense, the Division determines it is in the best interest of the integrity of Medicaid or Health
16 Choice to do so: any criminal offenses as set forth in any of the following Articles of Chapter
17 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article
18 5A, Endangering Executive, Legislative, and Court Officers; Article 6, Homicide; Article 7A,
19 Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction;
20 Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material;
21 Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article
22 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and
23 Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit
24 Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20,
25 Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article
26 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery;
27 Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article
28 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the
29 Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes
30 also include possession or sale of drugs in violation of the North Carolina Controlled
31 Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses
32 such as sale to underage persons in violation of G.S. 18B-302, or driving while impaired in
33 violation of G.S. 20-138.1 through G.S. 20-138.5.

34 **"§ 108C-5. Payment suspension and audits utilizing extrapolation.**

35 (a) The Department may suspend payments to a provider in accordance with the
36 requirements and procedures set forth in 42 C.F.R. § 455.23.

37 (b) In addition to the procedures for suspending payment set forth at 42 C.F.R. §
38 455.23, the Department may also suspend payment to any provider that (1) owes a final
39 overpayment, assessment, or fine to the Department and has not entered into an approved
40 payment plan with the Department; or (2) has had its participation in the Medicaid or Health
41 Choice programs suspended or terminated by the Department. For purposes of this Section, a
42 suspension or termination of participation does not become final until all administrative appeal
43 rights have been exhausted and shall not include any agency decision that is being contested at
44 the Department or the Office of Administrative Hearings or in Superior Court provided that the
45 Superior Court has entered a stay pursuant to the provisions of G.S. § 150B-48.

46 (c) For providers who owe a final overpayment, assessment, or fine to the Department,
47 the payment suspension shall begin the thirty-first day after the overpayment, assessment, or
48 fine becomes final. The payment suspension shall not exceed the amount owed to the
49 Department, including any applicable penalty and interest charges.

1 (d) Providers whose participation in the Medicaid or Health Choice programs has been
2 suspended or terminated shall have all payments suspended beginning on the thirty-first day
3 after the suspension or termination becomes final.

4 (e) The Department shall consult with the N.C. Departments of Treasury and Revenue
5 and other State departments and agencies to determine if a provider owes debts or fines to the
6 State. The Department may collect any of these debts owed to the State subsequent to
7 consideration by the Department of the financial impact upon the provider and the impact upon
8 access to the services provided by the provider.

9 (f) When issuing payment suspensions in accordance with this Chapter, the Department
10 may suspend payment to all providers which share the same IRS Employee Identification
11 Number or corporate parent as the provider or provider site location which owes the final
12 overpayment, assessment, or fine. The Department shall give 30 days advance written notice to
13 all providers which share the same IRS Employee Identification Number or corporate parent as
14 the provider or provider site location of the intention of the Department to implement a
15 payment suspension.

16 (g) The Department is authorized to approve a payment plan for a provider to pay a
17 final overpayment, assessment, or fine including interest and any penalty. The payment plan
18 can include a term of up to 24 months. The Department shall establish in rule the conditions of
19 such provider payment plans. Nothing in this subsection shall prevent the provider and the
20 Department from mutually agreeing to modifications of a payment plan.

21 (h) All payments suspended in accordance with this Chapter shall be applied toward
22 any final overpayment, assessment, or fine owed to the Department.

23 (i) Prior to extrapolating the results of any audits, the Department shall demonstrate
24 and inform the provider that: 1) the provider failed to substantially comply with the
25 requirements of State or federal law or regulation or 2) the Department has credible allegation
26 of fraud concerning the provider.

27 (j) Audits that result in the extrapolation of results must be performed and reviewed by
28 individuals who shall be credentialed by the Department, as applicable, in the matters to be
29 audited, including but not limited to coding or specific clinical issues.

30 (k) The Department, prior to conducting audits that result in the extrapolation of results
31 shall identify to the provider the matters to be reviewed and specifically list the clinical
32 (including but not limited to assessment of medical necessity), coding, authorization or other
33 matters reviewed and the time periods reviewed

34 (l) For those matters and time periods identified in subsection (k) of this section, the
35 provider shall not be subject to further audits by the Department, unless the Department
36 receives a credible allegation of fraud concerning the same time period or the federal
37 government initiates action based on allegations of fraud or other illegal activity for the same
38 time period.

39 (m) The Department may specify in rules the means by which a provider may conduct
40 voluntary self-audits upon matters subject to audit by the Department. The Department has the
41 authority to review the self-audit for compliance with requirements of State or federal law and
42 regulation and may reject any self-audit conducted by a provider found not in compliance.
43 Upon the provider's payment or payment agreement for any final overpayment, assessment, or
44 fine arising from the provider's self-audit, the provider shall not be subject to further audits by
45 the Department of the matters and time periods subject to the provider's self-audit, except
46 where the Department has received a credible allegation of fraud or the federal government
47 initiates action based on allegations of fraud or other illegal activity for the same time period.

48 (n) The results of audits that result in the extrapolation of results may be challenged by
49 a provider within the limited or moderate risk categories, pursuant to G.S. 108C-3.

50 (1) The provider shall notify the Department within 15 days of receipt of the
51 tentative audit results of the provider's challenge of the Department's results

under this subsection. The provider's notification shall select the means of challenging the error rate found by the Department.

(2) The provider may challenge the error rate found by the Department by doing one of the following:

a. Conducting a 100% file review of those matters and time periods identified in subsection (k) of this section and providing the results to the Department within sixty days from the date of the receipt of the Department's notice of tentative audit results.

b. Conducting a second audit upon a sample identified and produced by the Department utilizing the same statistical and sampling methodology to produce a sample twice the size of the original sample to review those matters and time periods identified in subsection (k). The Department shall provide a new sample to the provider within 30 days from the date of receipt of a provider's request. The provider shall have 60 days from receipt of the new sample to conduct the audit and provide the results to the Department.

(3) The results of an audit conducted by the provider pursuant to this subsection shall be binding upon the provider. The Department has the authority to review the provider's audit for compliance with the requirements of State and federal law and regulation and may reject any audit conducted by a provider pursuant to this subsection found not in compliance.

(4) Nothing in this subsection shall limit a provider from challenging the statistical methodology of the Department's original sample or the credentials of the individuals who performed and reviewed the audit.

(o) The Department shall permit limited correction of clerical, typographical, scrivener's, and computer errors by the provider prior to final determination of any audit.

(p) The provider shall have no less than thirty days from the date of the receipt of the Department's notice of tentative audit results to provide additional documentation not provided to the Department during any audit.

(q) Except as required by federal agency, law, or regulation, or instances of credible allegation of fraud, the provider shall be subject to audits which result in the extrapolation of results for a time period of up to 36 months from date of payment of a provider's claim.

(r) At least annually, the Department shall publish notice of the intention to use audits that result in the extrapolation of results upon its web site. Such notice shall include the services, provider types, audit elements, and the time periods subject to audit.

(s) Nothing in this Chapter shall be construed to prevent the Department from conducting unannounced or targeted audits of providers.

"§ 108C-6. Agents, clearinghouses, and alternate payees; registration required.

The Department is authorized to establish a registry of billing agents, clearinghouses, and/or alternate payees that submit claims on behalf of providers and to charge a fee to recover the costs of maintaining the registry in accordance with the 42 U.S.C. §1396a(a)(79) and implementing regulations. All billing agents, clearinghouses, or alternate payees shall register with the Department before submitting claims on behalf of providers or within six months of enactment of this Chapter, whichever is later. Any billing agent, clearinghouse, or alternate payee that fails to register with the Department prior to submitting claims on behalf of providers shall be excluded from the registry for a period not to exceed one year.

"§ 108C-7. Prepayment claims review.

(a) In order to ensure that claims presented by a provider for payment by the Department meet the requirements of federal and State laws and regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review by the

1 Department. Grounds for being placed on prepayment claims review shall include, but shall not
2 be limited to, receipt by the Department of credible allegations of fraud, identification of
3 aberrant billing practices as a result of investigations or data analysis performed by the
4 Department or other grounds as defined by the Department in rule.

5 (b) Providers shall not be entitled to payment prior to claims review by the Department.
6 The Department shall notify the provider in writing of the decision and the process for
7 submitting claims for prepayment claims review no less than 20 calendar days prior to
8 instituting prepayment claims review. The notice shall contain the following:

9 (1) An explanation of the Department's decision to place the provider on
10 prepayment claims review.

11 (2) A description of the review process and claims processing times.

12 (3) A description of the claims subject to prepayment claims review.

13 (4) A specific list of all supporting documentation that the provider will need to
14 submit contemporaneously with the claims that will be subject to the
15 prepayment claims review.

16 (5) The process for submitting claims and supporting documentation.

17 (6) The standard of evaluation used by the Department to determine when a
18 provider's claims will no longer be subject to prepayment claims review.

19 (c) For any claims in which the Department has given prior authorization, prepayment
20 review shall not include review of the medical necessity for the approved services.

21 (d) The Department shall process all clean claims submitted for prepayment review
22 within 20 calendar days of submission by the provider. If the provider failed to provide any of
23 the specifically requested supporting documentation necessary to process a claim pursuant to
24 this section, the Department shall send to the provider written notification of the lacking or
25 deficient documentation within 15 calendar days of receipt of such claim. The Department shall
26 have an additional 20 days to process a claim upon receipt of the documentation.

27 (e) The provider shall remain subject to the prepayment claims review process until the
28 provider achieves three consecutive months with a minimum seventy percent (70%) clean
29 claims rate. If the provider does not meet this standard within six months of being placed on
30 prepayment claims review, the Department may implement sanctions, including termination of
31 the applicable Medicaid Administrative Participation Agreement, or continuation of
32 prepayment review for an additional six-month period. The Department shall give adequate
33 advance notice of any modification, suspension or termination of the Medicaid Administrative
34 Participation Agreement. In no instance shall prepayment claims review continue longer than
35 12 months.

36 (f) The decision to place or maintain a provider on prepayment claims review does not
37 constitute a contested case under Chapter 150B of the General Statutes. A provider may not
38 appeal or otherwise contest a decision of the Department to place a provider on prepayment
39 review.

40 **"§ 108C-8. Threshold recovery amount.**

41 The Department shall not pursue recovery of Medicaid or Health Choice overpayments
42 owed to the State for any total amount less than one hundred fifty dollars (\$150.00) unless
43 directed to do so by the Centers for Medicare and Medicaid Services or unless such recovery
44 would be cost-effective and in the best interest of the State of North Carolina and Medicaid
45 recipients.

46 **"§ 108C-9. Provider enrollment criteria.**

47 (a) Applicants who submit an initial application for enrollment in North Carolina
48 Medicaid or North Carolina Health Choice, shall be required to submit an attestation and
49 complete trainings prior to being enrolled.

50 (b) The applicant's attestation shall contain a statement that the applicant's organization
51 has met the minimum business requirements necessary to comply with all federal and State

requirements governing the Medicaid and Children's Health Insurance programs, does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission, does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice programs or any other State Medicaid or Children's Health Insurance program, and has implemented a corporate compliance program as required under federal law. The Department shall set forth by rule the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance Program.

(c) Prior to being initially enrolled in the North Carolina Medicaid or Health Choice programs, an applicant's representative shall attend trainings as designated by the Department in rules, including but not limited to the following:

- (1) The Basic Medicaid Billing Guide, common billing errors, and how to avoid them.
- (2) Audit procedures, including explanation of the process by which the Department extrapolates audit results.
- (3) How to identify Medicaid recipient fraud.
- (4) How to report suspected fraud or abuse.
- (5) Medicaid recipient due process and appeal rights.

Online training shall be available for completion through the Department's website. The Department may charge a fee to recover costs of such trainings.

(d) Making any materially false or misleading statement in an attestation or enrollment application shall be grounds for denial, termination of, or permanent exclusion from enrollment in the North Carolina Medicaid or North Carolina Health Choice programs.

(e) The approval or acceptance of a Medicaid administrative participation or enrollment agreement by the Department that grants Medicaid billing privileges or allows a provider to furnish services under the North Carolina State Plan for Medical Assistance in accordance with 42 C.F.R. §431.107 requires compliance by the provider and the Department with the terms of the Medicaid administrative participation or enrollment agreement.

"§ 108C-10. Change of ownership and successor liability.

(a) For providers subject to this Chapter, any of the following occurrences shall constitute a change of ownership:

- (1) In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by Chapter 59 of the General Statutes.
- (2) In the case of a Limited Liability Company (LLC), the withdrawal or removal of a member, or when a person acquires a membership interest from the LLC or when a business entity converts or merges into the LLC pursuant to Chapter 57A of the General Statutes.
- (3) In the case of an unincorporated sole proprietorship, the transfer of title and property of the provider that constitute the provider's business of providing services, goods, supplies, or merchandise to a Medicaid or Health Choice recipient to another party.
- (4) The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. Transfer of corporate stock or the merger of another corporation into the provider corporation shall not constitute change of ownership. Merger of related provider corporations shall not constitute a change in ownership.
- (5) The lease of all or part of a provider's facility that will continue to be utilized for the provision of services, goods, supplies, or merchandise to a Medicaid

or Health Choice recipient shall constitute a change of ownership of the leased portion.

(b) A provider must notify the Department at least 30 calendar days prior to the effective date of any change of ownership.

(c) An assigned Medicaid administrative participation or enrollment agreement shall be subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, both of the following:

(1) Any existing plan of correction.

(2) Payment of any outstanding final overpayments, assessments, or fines owed to the Department.

(d) The Department shall not as a condition of enrollment require a provider to accept an assigned Medicaid administrative participation or enrollment agreement upon a change in ownership.

"§ 108C-11. Cooperation with investigations and audits.

(a) Providers shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the Department. Providers who fail to grant prompt and reasonable access or who fail to timely provide specifically designated documentation to the Department may be terminated from the North Carolina Medicaid or North Carolina Health Choice programs.

(b) The Department shall make all attempts to examine documentation without interfering with the clinical activities of the provider while conducting activities on the provider's premises.

(c) Nothing in this Chapter shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

"§ 108C-12. Appeals by Medicaid Providers and Applicants.

(a) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid provider or applicant to appeal an adverse determination made by the Department.

(b) Appeals. – Except as provided by this section a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes.

(c) Final Decision. – The Office of Administrative Hearing shall make a final decision within 180 days of the date of filing of the appeal with the Office of Administrative Hearings. The time to make a final decision shall be extended in the event of delays caused or requested by the Department.

(d) Burden of Proof. – The Department shall have the burden of proof in appeals of Medicaid providers or applicants concerning an adverse determination."

SECTION 2. G.S. 150B-1(d)(9) reads as rewritten:

"(9) The Department of Health and Human Services in adopting new or amending existing medical coverage policies under the State Medicaid Program pursuant to G.S. 108A-54.2."

SECTION 3. G.S. 150B-1(e) reads as rewritten:

"(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(16) ~~The Department of Health and Human Services with respect to contested cases commenced by (i) Medicaid providers appealing a denial or reduction~~

1 ~~in reimbursement for community support services, and (ii) community~~
2 ~~support services providers appealing decisions by the LME to deny or~~
3 ~~withdraw the provider's endorsement.~~

4 (17) The Department of Health and Human Services with respect to the review of
5 North Carolina Health Choice Program determinations regarding delay,
6 denial, reduction, suspension, or termination of health services, in whole or
7 in part, including a determination about type or level of services."

8 **SECTION 4.** G.S. 108C-5 as enacted by Section 1 of this act is effective when the
9 bill becomes law and applies to audits instituted on or after that date and to final overpayments,
10 assessments, or fines due on or after that date. G.S. 108C-6 as enacted by Section 1 of this act
11 becomes effective January 1, 2012. The remainder of the act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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1

SENATE BILL 552

Short Title: Regional Public Health Authority Pilot.

(Public)

Sponsors: Senator Hartsell.

Referred to: Health Care.

April 12, 2011

A BILL TO BE ENTITLED

AN ACT TO PROMOTE EFFICIENCY AND EFFECTIVENESS IN THE LOCAL PUBLIC HEALTH DELIVERY SYSTEM BY DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO CREATE INCENTIVES FOR SMALL COUNTY HEALTH DEPARTMENTS TO BECOME REGIONAL PUBLIC HEALTH AUTHORITIES.

The General Assembly of North Carolina enacts:

SECTION 1. The Health and Wellness Trust Fund Commission shall allocate from available Health and Wellness Trust Fund funds in the 2011-2012 fiscal year the sum of up to six million dollars (\$6,000,000) to the Department of Health and Human Services, which shall be credited to a nonreverting account within the Department. Funds in the account shall be used to establish and promote the formation of regional public health authorities through the provision of the incentive funding pilot established by the Department of Health and Human Services, Division of Public Health, in accordance with this act.

SECTION 2. The Department shall implement a regional public health authority incentive funding pilot program as follows: (i) Counties shall create a public health authority in accordance with G.S. 130A-45.02(b); (ii) to qualify for incentive funding, the regional authority shall provide health services in a catchment that includes either a minimum of 15 counties or contains a minimum population of 500,000. Counties with populations of 500,000 or more shall be eligible to receive incentive funding only if they combine with another county; (iii) regions should coincide with boundaries of other preexisting health relevant districts and planning regions whenever possible; (iv) incentive funds shall be allocated to each county within the region with a minimum allocation of two dollars (\$2.00) per capita per year; (v) funding shall be limited to three consecutive yearly allocations; (vi) incentive funds shall be granted only after adoption of resolutions required to create the new regional health authority in accordance with G.S. 130A-45.02. Disbursement of funds shall be initiated at the beginning of the fiscal year following the creation of the new regional health authority. Any county that receives incentive funding pursuant to this section shall return one-third of the total incentive funding received if the county leaves the authority in order to operate as a single county health department.

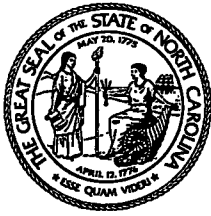
SECTION 3. The Department shall report by May 1, 2012, on the progress of the pilot project and shall include a review of the capacity of small counties to meet the core public health functions mandated by current State and federal law and whether the State should establish minimum populations for local health departments. The Department shall submit the report to the Public Health Study Commission, 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.



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SECTION 4. This act becomes effective July 1, 2011.



SENATE BILL 552: Incentive Program for Public Health Improvement

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S552-CSTK-15

Date: May 18, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *The Proposed Committee Substitute for Senate Bill 552 establishes a Public Health Improvement Incentive Program, limits State and federal pass through funding to health departments meeting certain statutory qualifications, codifies "the ten essential health services" of local health departments, and directs a study of the transfer of Division of Public Health from DHHS to the UNC Healthcare System.*

BILL ANALYSIS:

Section 1 establishes within the Department of Health and Human Services a Public Health Improvement Incentive Program to provide monetary incentives for local health departments to merge in order to serve catchments of 100,000 people or more and directs the Commission for Public Health to adopt rules to implement the program.

The section further provides that by July 1, 2014, in order to receive State and federal pass through funding a local health department shall be accredited, serve an area of 100,000 people or more, and be organized as a district health department, a single/multi-county health authority, or a consolidated human service agency created on or before January 1, 2011. The Secretary may grant an exception to local health departments that fail to meet the population threshold.

Counties are directed to maintain local health department funding at the greater of current fiscal year local ad valorem tax receipts or \$15.00 per capita.

Section 2 rewrites the essential public health services provision of the public health law and codifies ten essential public health services. *The ten essential public health services were originally created by a U.S. Centers for Disease Control and Prevention steering committee, working with representatives of U.S. Public Health Service agencies and other major national public health organizations to provide a working definition for local public health systems.*

Section 3 directs the Department to allocate \$5,000,000 from funds appropriated to the Division of Public Health to implement the Public Health Improvement Incentive Program.

Section 4 directs the Program Evaluation Division to study the feasibility of a transfer of functions, duties, and obligations of the Division of Public Health to the University of North Carolina Healthcare System and provide a report by February 1, 2012.

EFFECTIVE DATE: Section 3 of the act is effective July 1, 2011, and the remainder of the act becomes effective when the bill becomes law.

S552-SMSQ-30(CSTK-15) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 552
PROPOSED COMMITTEE SUBSTITUTE S552-CSTK-15 [v.7]

5/31/2011 3:42:03 PM

Short Title: Incentive Program for Public Health Improv.

(Public)

Sponsors:

Referred to:

April 12, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO PROMOTE EFFICIENCY AND EFFECTIVENESS IN THE PUBLIC HEALTH
3 SYSTEM BY ESTABLISHING A PUBLIC HEALTH IMPROVEMENT INCENTIVE
4 PROGRAM, STRENGTHENING LOCAL PUBLIC HEALTH INFRASTRUCTURE,
5 AND ASSURING THE PROVISION OF THE TEN ESSENTIAL PUBLIC HEALTH
6 SERVICES.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. Article 2 of Chapter 130A of the General Statutes is amended by
9 adding the following new sections to read:

10 "**§ 130A-34.2. Incentive program for public health improvement.**

11 (a) In order to promote efficiency and effectiveness of the public health delivery
12 system, the Department shall establish a Public Health Improvement Incentive Program. The
13 Program shall provide monetary incentives for the creation and expansion of multi-county local
14 health departments serving a population of not less than 100,000.

15 (b) The Commission shall adopt rules to implement the Public Health Improvement
16 Incentive Program.

17 "**§ 130A-34.3. Strengthening local public health infrastructure.**

18 (a) By July 1, 2014, in order for a local health department to be eligible to receive state
19 and federal public health funding from the Division of Public Health, the following criteria
20 shall be met:

21 (1) A local health department shall:

22 a. Obtain and maintain accreditation pursuant to G.S. 130A-34.1.

23 b. Have a service area that comprises a population of 100,000 or more.

24 c. Be organized as a (i) single-county or multi-county public health authority
25 created pursuant to G.S. 130A-45.02, (ii) a district health department
26 created pursuant to G.S. 130A-36, or (iii) a consolidated human
27 services agency created prior to January 1, 2011, pursuant to
28 G.S. 153A-77.

29 (2) The county or counties comprising the local health department shall
30 maintain appropriations to local health departments from local ad valorem
31 tax receipts at levels equal to amounts appropriated in State fiscal year
32 2010-2011 or fifteen dollars (\$15.00) per capita, whichever is greater.

33 (b) The criteria established in subsection (a) shall be in addition to any other funding
34 criteria established in by State or federal law.



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(c) Upon request of a local health department and for good cause shown the State Health Director may grant exceptions to population requirements contained in subsection (a)(1)(b) of this section.

SECTION 2. G.S. 130A-1.1(b) is rewritten to read:

"(b) A local health department shall assure that the following ten essential public health services are available and accessible to the population in each county served by the local health department:

- (1) Monitoring health status to identify community health problems.
- (2) Diagnosing and investigating health hazards in the community.
- (3) Informing, educating, and empowering people about health issues.
- (4) Mobilizing community partnerships to identify and solve health problems.
- (5) Developing policies and plans that support individual and community health efforts.
- (6) Enforcing laws and regulations that protect health and ensure safety.
- (7) Linking people to needed personal health care services and assuring the provision of health care when otherwise unavailable.
- (8) Assuring a competent public health workforce and personal health care workforce.
- (9) Evaluating effectiveness, accessibility, and quality of personal and population-based health services.
- (10) Conducting research.

~~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; 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.~~

SECTION 3. The Department of Health and Human Services shall allocate, from funds appropriated, the sum of five million dollars (\$5,000, 000) to the Division of Public

1 Health to provide incentives to local health departments through the Public Health
2 Improvement Incentive Program.

3 **SECTION 4.** The Program Evaluation Division of the General Assembly shall
4 study the feasibility of the transfer of all functions, powers, duties, and obligations vested in the
5 Division of Public Health in the Department of Health and Human Services to the University of
6 North Carolina Healthcare System and submit its findings and recommendations to the Joint
7 Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight
8 Committee on Health and Human Services no later than February 1, 2012.

9 **SECTION 5.** Section 3 of this act becomes effective July 1, 2011. The remainder
10 of this act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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1

SENATE BILL 617

Short Title: LRC Study Food Allergy & Anaphylaxis Mgmt.

(Public)

Sponsors: Senator Atwater.

Referred to: Health Care.

April 19, 2011

A BILL TO BE ENTITLED

**AN ACT TO REQUIRE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY
IMPLEMENTATION OF FEDERAL FOOD ALLERGY AND ANAPHYLAXIS
MANAGEMENT GUIDELINES IN PUBLIC SCHOOLS.**

Whereas, food allergies are a potentially life-threatening medical condition that afflicts approximately 12 million Americans, or one out of every 25 persons; and

Whereas, the Centers for Disease Control and Prevention reported an average of 317,000 food allergy-related, ambulatory care visits per year to emergency and outpatient departments and physician's offices involving children under 18 years of age; and

Whereas, in a survey of 400 elementary school nurses, 44% reported an increase in children with food allergies in their schools over the last five years; and

Whereas, peanut allergy alone tripled among children from 1997 to 2008; and

Whereas, all children deserve a safe and healthy learning environment; and

Whereas, there is no cure for food allergies; strict avoidance is the only way to prevent a reaction; and

Whereas, the importance of managing students with food allergies has been recognized by the American Medical Association, the American Academy of Pediatrics, the American Academy of Allergy, Asthma and Immunology, the National Association of School Nurses, the National Association of Elementary School Principals, and the National School Boards Association; and

Whereas, in the past decade, 12 states have published statewide guidance to help schools manage food-allergic students, with similar guidelines expected to be published soon in three additional states; and

Whereas, there is a lack of consistent training guidelines at both the State and federal level; and

Whereas, a life-threatening food allergy is a condition recognized as a disability by the United States Department of Agriculture, the United States Department of Transportation, and the United States Department of Education's Office for Civil Rights; and

Whereas, the Food Allergy and Anaphylaxis Management Act (FAAMA) was signed into law on January 4, 2011; and

Whereas, FAAMA requires the United States Secretary of Health and Human Services to develop and make available to schools a voluntary policy to manage the risks of food allergy and anaphylaxis in schools; and

Whereas, FAAMA provides for school-based food allergy management incentive grants to support implementation of food allergy management guidelines in public schools; Now, therefore,

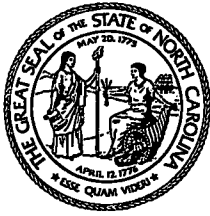
The General Assembly of North Carolina enacts:



1 **SECTION 1.(a)** The Legislative Research Commission shall study the feasibility
2 of implementing guidelines developed by the United States Secretary of Health and Human
3 Services in consultation with the United States Secretary of Education, pursuant to the Food
4 Allergy and Anaphylaxis Management Act, to manage the risks of food allergy and anaphylaxis
5 in all public elementary schools, public middle schools, and public high schools in this State.
6 The Commission is also authorized to investigate opportunities for local educational agencies
7 to receive grants under FAAMA to assist with implementing federal food allergy and
8 anaphylaxis management guidelines. In completing this study, the Commission shall solicit
9 input from interested parties, including parents of children with life-threatening food allergies,
10 health care professionals with experience in treating children with life-threatening food
11 allergies, the State Board of Education, and the Division of Public Health of the North Carolina
12 Department of Health and Human Services.

13 **SECTION 1.(b)** The Legislative Research Commission may make an interim
14 report on its findings and recommendations to the 2011 General Assembly when it reconvenes
15 in 2012 and shall make its final report to the 2013 General Assembly.

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



SENATE BILL 617: LRC Study Food Allergy & Anaphylaxis Mgmt

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Atwater
Analysis of: PCS to First Edition
S617-CSTE-3

Date: May 31, 2011
Prepared by: Susan Barham
Research Assistant

SUMMARY: *The Proposed Committee Substitute (PCS) for Senate Bill 617 authorizes the Legislative Research Commission (LRC) to study implementing guidelines to manage the risks of food allergies and anaphylaxis in all public schools in North Carolina.*

BILL ANALYSIS:

The PCS for Senate Bill 617 allows the LRC to study:

- The feasibility of implementing voluntary guidelines, developed by the U.S. Secretary of Health and Human Services, to manage the risks of food allergies and anaphylaxis in all public elementary, middle, and high schools in this State.
- Opportunities for local educational agencies to receive grants under the Food Allergy and Anaphylaxis Management Act to assist with implementation of the federal guidelines.

The PCS permits the LRC to request input from interested parties including: (1) parents of children with life threatening allergies, (2) health care professionals experienced with treating children with life threatening allergies, (3) the State Board of Education, and (4) the Division of Public Health, Department of Health and Human Services.

If the LRC undertakes this study, the LRC may provide an interim report to the 2012 General Assembly and must make a final report to the 2013 General Assembly.

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

BACKGROUND:

The Food Allergy and Anaphylaxis Management Act (FAAMA) was signed into law on January 4, 2011. By January 2012, the U.S. Secretary of Health and Human Services is required to develop and make available to schools a voluntary policy to manage the risk of food allergy and anaphylaxis in schools. FAAMA also provides for school-based incentive grants to support implementation of food allergy management guidelines in public schools.

S617-SMTE-11(CSTE-3) v2

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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**SENATE BILL 617
PROPOSED COMMITTEE SUBSTITUTE S617-CSTE-3 [v.2]**

5/31/2011 1:52:00 PM

Short Title: LRC Study Food Allergy & Anaphylaxis Mgmt.

(Public)

Sponsors:

Referred to:

April 19, 2011

A BILL TO BE ENTITLED

**AN ACT AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY
IMPLEMENTATION OF FEDERAL FOOD ALLERGY AND ANAPHYLAXIS
MANAGEMENT GUIDELINES IN PUBLIC SCHOOLS.**

Whereas, food allergies are a potentially life-threatening medical condition that afflicts approximately 12 million Americans, or one out of every 25 persons; and

Whereas, the Centers for Disease Control and Prevention reported an average of 317,000 food allergy-related, ambulatory care visits per year to emergency and outpatient departments and physician's offices involving children under 18 years of age; and

Whereas, in a survey of 400 elementary school nurses, 44% reported an increase in children with food allergies in their schools over the last five years; and

Whereas, peanut allergy alone tripled among children from 1997 to 2008; and

Whereas, all children deserve a safe and healthy learning environment; and

Whereas, there is no cure for food allergies; strict avoidance is the only way to prevent a reaction; and

Whereas, the importance of managing students with food allergies has been recognized by the American Medical Association, the American Academy of Pediatrics, the American Academy of Allergy, Asthma and Immunology, the National Association of School Nurses, the National Association of Elementary School Principals, and the National School Boards Association; and

Whereas, in the past decade, 12 states have published statewide guidance to help schools manage food-allergic students, with similar guidelines expected to be published soon in three additional states; and

Whereas, there is a lack of consistent training guidelines at both the State and federal level; and

Whereas, a life-threatening food allergy is a condition recognized as a disability by the United States Department of Agriculture, the United States Department of Transportation, and the United States Department of Education's Office for Civil Rights; and

Whereas, the Food Allergy and Anaphylaxis Management Act (FAAMA) was signed into law on January 4, 2011; and

Whereas, FAAMA requires the United States Secretary of Health and Human Services to develop and make available to schools a voluntary policy to manage the risks of food allergy and anaphylaxis in schools; and



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1 Whereas, FAAMA provides for school-based food allergy management incentive
2 grants to support implementation of food allergy management guidelines in public schools;
3 Now, therefore,

4 The General Assembly of North Carolina enacts:

5 **SECTION 1.(a)** The Legislative Research Commission may study the feasibility of
6 implementing guidelines developed by the United States Secretary of Health and Human
7 Services in consultation with the United States Secretary of Education, pursuant to the Food
8 Allergy and Anaphylaxis Management Act, to manage the risks of food allergy and anaphylaxis
9 in all public elementary schools, public middle schools, and public high schools in this State.
10 The Commission is also authorized to investigate opportunities for local educational agencies
11 to receive grants under FAAMA to assist with implementing federal food allergy and
12 anaphylaxis management guidelines. In completing this study, the Commission may solicit
13 input from interested parties, including parents of children with life-threatening food allergies,
14 health care professionals with experience in treating children with life-threatening food
15 allergies, the State Board of Education, and the Division of Public Health of the North Carolina
16 Department of Health and Human Services.

17 **SECTION 1.(b)** The Legislative Research Commission may make an interim
18 report on its findings and recommendations to the 2011 General Assembly when it reconvenes
19 in 2012 and shall make its final report to the 2013 General Assembly.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 246

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors: Senators Hartsell; Atwater and Mansfield.

Referred to: Health Care.

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
IMMUNIZING PHARMACISTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.3(r) reads as rewritten:

"(r) ~~"Practice of pharmacy" means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4 is as specified in G.S. 90-85.3A."~~

SECTION 2. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.3A. Practice of pharmacy.

(a) A pharmacist is responsible for interpreting and evaluating drug orders, including prescription orders; compounding, dispensing, and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services.

(b) A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses, and significant problems of drugs and devices; assess, record, and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record, and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

(c) A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by



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each of the following: The Board of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(d) An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.

(e) A pharmacist who (i) holds a current provider level cardiopulmonary resuscitation certification issued by the American Heart Association or the American Red Cross, or an equivalent certification, (ii) has successfully completed a certificate program in vaccine administration accredited by the Centers for Disease Control and Prevention, the Accreditation Council for Pharmacy Education, or a similar health authority or professional body approved by the Board, (iii) maintains documentation of three hours of continuing education every two years, designed to maintain competency in the disease states, drugs, and vaccine administration, and (iv) has successfully completed training approved by the Division of Public Health's Immunization Branch for participation in the North Carolina Immunization Registry may administer any vaccine or immunization recommended or required by the Centers for Disease Control and Prevention, including a vaccine for travel outside the United States, subject to the following limitations and requirements:

- (1) A pharmacist may administer a vaccine or immunization to a minor who is at least seven years of age, but less than 14 years of age, only (i) pursuant to a specific prescription order and (ii) at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.
- (2) A pharmacist may administer a vaccine or immunization without a specific prescription order to a minor who is at least 14 years of age, but less than 18 years of age, only at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.
- (3) A pharmacist may administer a vaccine or immunization without a specific prescription order to any patient 18 years of age or older, at the patient's request.
- (4) A pharmacist who administers a vaccine or immunization to any patient pursuant to this subsection shall do all of the following:
 - a. Maintain a record of any vaccine or immunization administered to the patient in a patient profile.
 - b. If the patient has identified a primary care provider, notify the patient's primary care provider of any vaccine or immunization administered to the patient within 24 hours after administration.
 - c. Record any vaccine or immunization administered to the patient in the North Carolina Immunization Registry within 24 hours after administration."

SECTION 3. G.S. 130A-153 reads as rewritten:

"(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or from medicine;~~ a local health ~~department.~~ department; or a pharmacist, in accordance with the provisions of G.S. 90-85.3A(e). Local health departments shall administer required and State-supplied immunizations at no cost to uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health

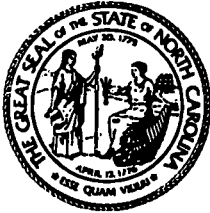
1 departments, a pharmacist administering the required immunization in accordance with
2 G.S. 90-85.3A(e), and the patient's attending physician. In addition, an insurance institution,
3 agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may
4 share immunization information with the Department. The Commission may, for the purpose of
5 assisting the Department in enforcing this Part, provide by rule that other persons may have
6 access to immunization information, in whole or in part.

7 (d) A ~~physician~~physician, pharmacist, or local health department may immunize a
8 minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A
9 ~~physician~~physician, pharmacist, or local health department may also immunize a minor who is
10 presented for immunization by an adult who signs a statement that he or she is authorized by a
11 parent, guardian, or person standing in loco parentis to the minor to obtain the immunization
12 for the minor. Notwithstanding any other provision of this Chapter, a pharmacist's authority to
13 administer vaccines or immunizations to a minor is limited to the authority specified in
14 G.S. 90-85.3A(e)."

15 **SECTION 4.** G.S. 130A-154(a) reads as rewritten:

16 "(a) A ~~physician~~physician, pharmacist, or local health department administering a
17 required vaccine shall give a certificate of immunization to the person who presented the child
18 for immunization. The certificate shall state the name of the child, the name of the child's
19 parent, guardian, or person responsible for the child obtaining the required immunization, the
20 address of the child and the parent, guardian or responsible person, the date of birth of the
21 child, the sex of the child, the number of doses of the vaccine given, the date the doses were
22 given, the name and address of the ~~physician~~physician, pharmacist, or local health department
23 administering the required immunization and other relevant information required by the
24 Commission."

25 **SECTION 5.** This act becomes effective October 1, 2011.



SENATE BILL 246: Expand Pharmacists' Immunizing Authority

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S246-CSSQ-39

Date: June 2, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *The Proposed Committee Substitute to Senate Bill 246 authorizes an "immunizing pharmacist" (defined term) to administer certain vaccines or immunizations pursuant to protocols developed by the State Health Director in consultation with the North Carolina Board of Pharmacy with additional restrictions based on vaccine type or patient age.*

CURRENT LAW: Currently a pharmacist who has received special training is permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by the Board of Pharmacy, Board of Nursing, and Board of Medicine.

The current rule provides standards for pharmacists engaged in the administration of influenza, pneumococcal and zoster vaccines for persons 18 years and older.

BILL ANALYSIS: Senate Bill 246 amends the Pharmacy Practice Act as follows:

Section 1 directs the State Health Director to adopt rules by January 1, 2012, to provide standards for the administration of vaccines by pharmacists. The rules shall include: protocols per each vaccine recommended or required by the CDC and its application to categories of individuals to receive the vaccine; responsibilities of local health departments in overseeing the immunizing pharmacist, registration and additional requirements of immunizing pharmacists including record keeping, reporting, and safe handling of vaccines.

Section 2 defines the term "immunizing pharmacist" as a licensed pharmacist who holds a current CPR certification, completed a certificate program in vaccine administration, maintains documentation of continuing education in vaccine administration, has successfully completed training for participation in the NC Immunization Registry, enrolls with a local supervising health department and administers vaccines or immunizations in accordance with the Article.

Sections 3 and 4 recodify the definition of the practice of pharmacy as a new section G.S. 90-85.3A, but adds the authority for an immunizing pharmacist to administer drugs in accordance to rules adopted by the State Health Director.

Section 5 authorizes an immunizing pharmacist to administer vaccines or immunizations in accordance with rules and with the following limitations:

Senate PCS 246

Page 2

Age	Not Administered	Administered Pursuant to Written Protocol	At the Request of:	Specific Prescription Order
Under 7 Years Old	X		N/A	N/A
At Least 7 < 18 Years Old (Flu Vaccine)		X	Parent/Guardian	N/A
At Least 7 < 14 Years Old (Vaccines other than Flu)		X	Parent/Guardian	With
At Least 14 < 18 Years Old		X	Parent/Guardian	With or Without
At Least 18 Years Old		X	Patient	With or Without

and requires an immunizing pharmacist who administers vaccines or immunizations to do the following:

- Maintain a record of the vaccine or immunization administered in the patient profile.
- Notify the primary care provider (if the patient so identifies) within 24 hours of the administration.
- Record any vaccine or immunization in the NC Immunization Registry within 24 hours of the administration.

Section 6 provides local health departments the authority to charge a fee for services performed (enrolling, oversight) pursuant to rules adopted to implement the act.

Sections 7-8 make conforming changes in the public health law to provide for an immunizing pharmacist.

Section 9 provides that the current rule governing the administration of vaccines by pharmacists remains in effect until new rules adopted to implement the act are effective, but reduces the age of influenza vaccine recipients from 18 to 14.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S246-SMSQ-35(CSSQ-39) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 246
PROPOSED COMMITTEE SUBSTITUTE S246-CSSQ-39 [v.3]

6/2/2011 10:21:44 AM

Short Title: Expand Pharmacists' Immunizing Authority. (Public)

Sponsors:

Referred to:

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
IMMUNIZING PHARMACISTS.

The General Assembly of North Carolina enacts:

SECTION 1. Not later than January 1, 2012, the State Health Director in consultation with the North Carolina Board of Pharmacy shall adopt rules to provide standards for the administration of immunizations by pharmacists in accordance with G.S. 90-85.15. The rules shall include the following:

(a) A protocol for any vaccine or immunization recommended or required by the Centers for Disease Control and Prevention, and its application to specified categories of individuals eligible to receive the vaccine. The protocol shall include any contraindications, emergency procedures, information to be disclosed to patients, and a procedure for annual updates on vaccine administration.

(b) Responsibilities of the local health department or physician overseeing the immunizing pharmacist. These responsibilities shall include record keeping procedures for protocols pertaining to immunizing pharmacists overseen by the local health department or physician, accessibility to the immunizing pharmacist for consultation, assistance, direction and back-up coverage.

(c) Registration of all immunizing pharmacists with the North Carolina Board of Pharmacists.

SECTION 2. G.S. 90-85.3 is amended by adding the following new subsections to read:

"(1) "Immunizing pharmacist" means a licensed pharmacist who meets all of the following qualifications:

(1) Holds a current provider level cardiopulmonary resuscitation certification issued by the American Heart Association or the American Red Cross, or an equivalent certification.

(2) Has successfully completed a certificate program in vaccine administration accredited by the Centers for Disease Control and Prevention, the Accreditation Council for Pharmacy Education, or a similar health authority or professional body approved by the Board.



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- (3) Maintains documentation of three hours of continuing education every two years, designed to maintain competency in the disease states, drugs, and vaccine administration.
- (4) Has successfully completed training approved by the Division of Public Health's Immunization Branch for participation in the North Carolina Immunization Registry.
- (5) Enrolls with a local supervising health department and pays an annual enrollment fee.
- (6) Administers vaccines or immunizations in accordance with G.S. 90-18.15B."

SECTION 3. G.S. 90-85.3(r) reads as rewritten:

"(r) ~~"Practice of pharmacy" means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.~~is as specified in G.S. 90-85.3A."

SECTION 4. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.3A. Practice of pharmacy.

(a) A pharmacist is responsible for interpreting and evaluating drug orders, including prescription orders; compounding, dispensing, and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services.

(b) A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses, and significant problems of drugs and devices; assess, record, and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record, and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

(c) An immunizing pharmacist may be authorized and permitted to administer drugs pursuant to a specific prescription order or pursuant to protocol in accordance with rules adopted by the State Health Director in consultation with the North Carolina Board of Pharmacy.

(d) A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(e) An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4.

SECTION 5. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.15B Immunizing pharmacists

(a) An immunizing pharmacist may administer vaccines or immunizations in accordance to rules adopted by the State Health Director, in consultation with the North Carolina Board of Pharmacy with the following limitations:

- (1) Vaccines or immunizations shall not be administered to patients under the age of seven.
- (2) For patients at least seven years of age, but less than 18 years of age, influenza vaccines shall only be administered (i) pursuant to protocol, and (ii) at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.
- (3) For patients at least seven years of age, but less than 14 years of age, vaccines or immunizations other than influenza vaccine shall only be administered (i) pursuant to a specific prescription order, (ii) pursuant to protocol, and (iii) at the request of the patient's parent, guardian, or person standing in loco parentis to the minor.
- (4) For patients at least 14 years of age, but less than 18 years of age, vaccines or immunizations shall be administered (i) pursuant to protocol or with a specific prescription order, and (ii) at the request of the of the patient's parent, guardian, or person standing in loco parentis to the minor.
- (5) For patients at least 18 years of age, vaccines or immunizations shall be administered pursuant to protocol or with a specific prescription order, at the request of the patient.

(c) An immunizing pharmacist who administers a vaccine or immunization to any patient pursuant to this section shall do all of the following:

- (1). Maintain a record of any vaccine or immunization administered to the patient in a patient profile.
- (2). If the patient has identified a primary care provider, notify the patient's primary care provider of any vaccine or immunization administered to the patient within 24 hours after administration.
- (3). Record any vaccine or immunization administered to the patient in the North Carolina Immunization Registry within 24 hours after administration."

SECTION 6. G.S. 130A-39(g) reads as rewritten:

"(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing", for services performed pursuant to G.S. 90-85.15B, and for services performed pursuant to G.S. 87-97. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

SECTION 7. G.S. 130A-153 reads as rewritten:

"(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or from medicine;~~ a local health ~~department.~~ ~~department;~~ or an immunizing

1 pharmacist, in accordance with the provisions of G.S. 90-85.15B. Local health departments
2 shall administer required and State-supplied immunizations at no cost to uninsured or
3 underinsured patients with family incomes below two hundred percent (200%) of the federal
4 poverty level. A local health department may redistribute these vaccines only in accordance
5 with the rules of the Commission.

6 (b) Local health departments shall file monthly immunization reports with the
7 Department. The report shall be filed on forms prepared by the Department and shall state, at a
8 minimum, each patient's age and the number of doses of each type of vaccine administered.

9 (c) Immunization certificates and information concerning immunizations contained in
10 medical or other records shall, upon request, be shared with the Department, local health
11 departments, immunizing pharmacist, and the patient's attending physician. In addition, an
12 insurance institution, agent, or insurance support organization, as those terms are defined in
13 G.S. 58-39-15, may share immunization information with the Department. The Commission
14 may, for the purpose of assisting the Department in enforcing this Part, provide by rule that
15 other persons may have access to immunization information, in whole or in part.

16 (d) A ~~physician-physician~~, immunizing pharmacist, or local health department may
17 immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to
18 the minor. A ~~physician-physician~~, immunizing pharmacist, or local health department may also
19 immunize a minor who is presented for immunization by an adult who signs a statement that he
20 or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to
21 obtain the immunization for the minor. Notwithstanding any other provision of this Chapter, an
22 immunizing pharmacist's authority to administer vaccines or immunizations to a minor is
23 limited to the authority specified in G.S. 90-85.15B."

24 **SECTION 8.** G.S. 130A-154(a) reads as rewritten:

25 "(a) A ~~physician-physician~~, immunizing pharmacist, or local health department
26 administering a required vaccine shall give a certificate of immunization to the person who
27 presented the child for immunization. The certificate shall state the name of the child, the name
28 of the child's parent, guardian, or person responsible for the child obtaining the required
29 immunization, the address of the child and the parent, guardian or responsible person, the date
30 of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the
31 doses were given, the name and address of the ~~physician-physician~~, immunizing pharmacist, or
32 local health department administering the required immunization and other relevant
33 information required by the Commission."

34 **SECTION 9.** 21 NCAC 46.2507 shall govern the administration of influenza,
35 pneumococcal and zoster vaccines by pharmacists until rules adopted to implement provisions
36 of this act become effective, provided however an immunizing pharmacists shall be granted the
37 authority to administer influenza vaccine to patients aged 14 years and older.

38 **SECTION 10.** This act becomes effective October 1, 2011.
39

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 655

Short Title: Dentistry Management Arrangements. (Public)

Sponsors: Senators Pate, Brunstetter, Allran; Apodaca, D. Berger, Brock, Purcell, and Stevens.

Referred to: Health Care.

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT DENTIST AGREEMENTS WITH MANAGEMENT COMPANIES DO NOT COMPROMISE THE FUNDAMENTAL PUBLIC PURPOSE OF THE DENTAL PRACTICE ACT, WHICH IS ENSURING THAT CITIZENS HAVE ACCESS TO HIGH QUALITY DENTAL CARE THAT IS OWNED, CONTROLLED, AND SUPERVISED BY LICENSED AND PROFESSIONAL DENTISTS WITH DEMONSTRATED CLINICAL SKILLS AND WHO ARE ACCOUNTABLE FOR THEIR DENTAL DECISIONS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-40.2. Management arrangements.

(a) No dentist, professional entity, or management company shall enter into a management arrangement unless the management arrangement meets the requirements of subsections (b) through (h) of this section.

(b) The following definitions apply in this section:

(1) Clinical. – Of or relating to the activities of a dentist as described in G. S. 90-29(b)(1) through (10).

(2) Management arrangement. – Any one or more contractual agreements, stipulations, understandings, arrangements, or other binding legal instruments or arrangements, by whatever name, whether written or oral, between a dentist or professional entity and a management company whereby the management company does any of the following:

a. Regularly provides services for the clinical-related business of a dentist or professional entity.

b. Exercises supervision, management, or control over the clinical, professional, or business aspects of a dentist or professional entity or the employees or contractors of the dental practice.

c. Provides control of business activities of the clinical or professional services of the dentist or professional entity.

(3) Management company. – Any individual, business corporation, nonprofit corporation, partnership, limited liability company, limited partnership, or other legal entity, by whatever name, other than a dentist licensed in this State or registered professional entity authorized to provide clinical dental services under this Article, that provides to a dentist or professional entity services described in sub-subdivisions (b)(2)a. through c. of this section.



* 5 6 5 5 - V - 1 *

- 1 (4) Professional entity. – A professional corporation, nonprofit corporation,
2 partnership, professional limited liability company, professional limited
3 partnership, or other entity or aggregation of individuals, by whatever name,
4 that is licensed, certified, or otherwise authorized to provide clinical dental
5 services under this Article.
- 6 (5) Unlicensed person. – Any person or entity, other than a dentist licensed in
7 this State or registered professional entity authorized to provide dental
8 services under this Article.
- 9 (c) All management arrangements shall meet the following requirements:
- 10 (1) Be submitted to the Board for a review and a determination of compliance
11 with this section and other provisions under this Article.
- 12 (2) Be evidenced by a written agreement that satisfies each of the following:
- 13 a. Is signed by all parties to the agreement.
- 14 b. Sets forth all material terms of the arrangement between or among
15 the parties to the agreement.
- 16 c. Describes all of the types of services to be provided by the
17 management company and the time periods during which those
18 services will be provided.
- 19 d. Sets forth the precise methodology for calculating the compensation
20 to be paid to the management company by the dentist or professional
21 entity and, whenever possible, the aggregate compensation to be paid
22 under the management arrangement.
- 23 e. Is implemented, administered, or carried out between the parties to
24 the agreement consistent with the terms of the writing.
- 25 (d) No management arrangement shall provide for or permit any provision, which alone
26 or in combination with others, (i) has a potential negative impact on patient care, (ii) affects the
27 provision of dental services, the professional decision-making of the dentist, or other personnel
28 of the dentist or professional entity, (iii) assigns control of the dental practice to a management
29 company or unlicensed person, or (iv) gives the entity or unlicensed person actual or effective
30 ownership of the dental practice.
- 31 (e) No management arrangement shall provide for or permit any of the following:
- 32 (1) Control over the distribution of a revenue stream or control over a line of
33 business of the professional entity, except for the sale of fixed assets of a
34 dentist or professional entity permitted under the laws of this State.
- 35 (2) Ownership or exclusive control of patient records of the dental practice.
- 36 (3) Direct or indirect control over, or input into, the clinical practices of the
37 professional entity or its dentists or clinical personnel.
- 38 (4) Direct or indirect control over the employment or termination of dentists,
39 dental hygienists, or other personnel of the dentist or professional entity by
40 the management company, including the authority to prescribe or limit the
41 material terms of all the personnel's relationship with the dentist or
42 professional entity or the ability to restrict or limit the authority of the dental
43 practice to arrange the work schedule of the personnel. This subdivision
44 shall not be construed to prohibit the use of temporary personnel by a dentist
45 or dental practice for a period not to exceed six months.
- 46 (5) Authority to enter into, approve, or require its input into any contract or
47 other arrangement or material terms of the contract or arrangement between
48 the professional entity and a dentist for the provision of dental services.
- 49 (6) Direct or indirect control over the transfer of ownership interests in the
50 professional entity including, without limitation, any agreement or

- 1 arrangement limiting or requiring in whole or in part the transfer of
2 ownership interests in a professional entity.
- 3 (7) Payment of compensation or anything of value based on or related to an
4 increase or decrease in collections, profits, gross or net revenues, proceeds,
5 earnings, or any other income, however characterized, of the dentist or
6 professional entity.
- 7 (8) Payment of compensation that is likely to or is designed to exceed the profits
8 of the professional entity where such an outcome is foreseeable at the time
9 the management agreement is executed.
- 10 (9) Payment of compensation without specifying the precise methodology by
11 which the dentist or dental practice can determine the increased or decreased
12 management fees due under the agreement based upon an inverse correlation
13 between the change in fees and the increases or decreases in cost to the
14 practice from the management company's performance.
- 15 (10) Payment of compensation without (i) stating precisely all the charges to the
16 dentist or dental practice for all services being provided under the
17 agreement, (ii) identifying the methodology by which the dentist or dental
18 practice can calculate the total amount owed for all services to the
19 management company under the agreement, or (iii) providing access to the
20 dentist or dental practice accurate documentation supporting charges under
21 the agreement and regular audit opportunities for the dentist or dental
22 practice.
- 23 (11) Authority or input into the determination of which patients are seen by the
24 dental practice, including prioritizing the types of patients that should be
25 seen by the dental practice, such as patient selection criteria based on payor
26 source.
- 27 (12) Authority to establish or to limit the hours of operation of the dentist or
28 dental practice or require the management company's or unlicensed person's
29 agreement to hours of operation of the dental practice.
- 30 (13) Power to require a dentist, professional entity, or dental practice to use its
31 services exclusively.
- 32 (14) Exclusive right to provide the dentist or dental practice all supplies,
33 equipment, inventory, or furnishings, including from an affiliate owned or
34 controlled by the management company or unlicensed person.
- 35 (15) Control of a dentist or dental practice's funds, including the use of 'sweep
36 accounts' pursuant to which the management company or unlicensed person
37 sweeps the funds from the accounts of the dentist or dental practice into a
38 master account maintained or controlled by the management company or
39 unlicensed person.
- 40 (16) Decision-making authority over priority of payment to vendors or suppliers
41 of the dentist or dental practice, including for the payment of its fees.
- 42 (17) Authority to require that the dentist or dental practice bill patients in the
43 name of the management company or that patient payments be made directly
44 to the company or an unlicensed person.
- 45 (18) Ownership of all equipment, supplies, or inventory of the practice.
- 46 (19) Authority to lease or sublease office space to be used for the provision of
47 clinical services to a dental practice in which the precise terms of the lease
48 are not clearly delineated or are not on commercially reasonable terms.
- 49 (20) Authority to lease or sublease dental equipment used to provide clinical
50 services to a dental practice in which the precise terms of the lease are not
51 clearly delineated or are not on commercially reasonable terms.

(21) Authority to require the licensee or professional entity to lease, sublease, or finance equipment used by a dental practice, which fails to provide for the continued use of the equipment by the dental practice on commercially reasonable terms after termination of the arrangement.

(22) Authority to lease or sublease office space for the provision of clinical services to a dental practice, which does not provide for the continued lease of the space on commercially reasonable terms after termination of the arrangement.

(23) Power to limit the ability of dentists who own or are employed by the dental practice to practice dentistry or provide clinical services other than in a dental practice associated with the management company or unlicensed person, such as a restrictive covenant or noncompetition clause.

(f) The provisions of subsection (e) of this section do not constitute an exhaustive list of management arrangement provisions which violate this section or other sections of this Article. The Board may, by rule or otherwise, identify other management arrangement provisions that violate this section or other provisions of this Article.

(g) Notwithstanding subdivisions (e)(7) and (e)(8) of this section, a management arrangement may do either of the following:

(1) Include a schedule of additional compensation to be paid to the management company during the term of a management agreement based upon the lowering of costs to the professional entity or dentist so long as any additional compensation is based upon a specified schedule or method of computing the additional compensation and is set forth in the management agreement.

(2) Include a schedule of decreased compensation to the management company during the term of the management agreement based upon increases in costs to the professional entity or dentist so long as any decreased compensation is based upon a specified schedule or method of computing the decreased compensation and is set forth in the management agreement.

(h) No dentist, professional entity, management company, or unlicensed person shall enter into an oral or written arrangement or scheme that the dentist or professional entity knows or should know has a material purpose of creating an indirect arrangement that, if entered into directly, would violate the provisions of this section.

(i) Upon submission for review, the Board shall issue a written advisory opinion concerning the compliance or noncompliance of a management agreement with this section. The Board may define by rule or otherwise the timing of and procedure for the review of management agreements required by this section.

(j) Any licensee or management company which is dissatisfied with the Board's advisory opinion that a proposed or existing management agreement violates any provision of this section or this Article shall be afforded notice of the opportunity to request a hearing before the Board. The proceedings shall be conducted pursuant to Article 3A of Chapter 150B of the General Statutes. In connection with the proceedings, the Board is hereby authorized and empowered to issue any orders, commissions, notices, subpoenas, or other process as might be necessary or proper to effect the purposes of this subsection. However, no member of the Board shall be subject to examination in connection with the proceedings.

(k) Anyone who enters into or renews any management arrangement before completion of the Board's review process or a hearing under Article 3A of Chapter 150B of the General Statutes, when applicable, does so subject to possible action by the Board if an executed management arrangement violates any provision of this Article. A licensed dentist is subject to possible disciplinary action pursuant to G.S. 90-41 and a management company or unlicensed person is subject to possible injunctive action pursuant to G.S. 90-40.1 for any noncompliant

1 management arrangement that is executed or in operation before the Board makes a final
2 determination about its compliance or noncompliance under this Article.

3 (l) All records, papers, investigative files, investigative reports, other investigative
4 information, and other documents containing information in the possession of, gathered by, or
5 reviewed by the Board in connection with the review of a management arrangement as required
6 by this section shall not be considered public records within the meaning of Chapter 132 of the
7 General Statutes and are privileged, confidential, and not subject to discovery, subpoena, or
8 other means of legal compulsion for release to any person other than the Board, its employees,
9 agents, or consultants except as provided in subsection (m) of this section. For purposes of this
10 subsection, investigative information includes information relating to the identify of, and a
11 report made by, a licensee or other person performing an expert review for the Board of a
12 management arrangement and transcripts of any deposition taken by Board counsel in
13 preparation for or in anticipation of a hearing requested pursuant to this section, but not
14 admitted into evidence at the hearing. However, any notice or statement of charges against any
15 licensee, any notice to any licensee of a hearing in any proceeding, or any notice of hearing to a
16 management company or unlicensed person issued pursuant to subsection (j) of this section,
17 shall be a public record within the meaning of Chapter 132 of the General Statutes even if it
18 may contain information collected and compiled as a result of any investigation, inquiry, or
19 interview. If any record, paper, or other document containing information collected and
20 compiled by the Board is received and admitted into evidence in any hearing before the Board
21 pursuant to this section, it shall then be a public record within the meaning of Chapter 132 of
22 the General Statutes.

23 (m) The Board shall provide a management company or licensee access to all
24 information in its possession that the Board intends to offer into evidence in presenting its case
25 in chief in a contested case hearing requested by the management company or licensee pursuant
26 to subsection (j) of this section, subject to any privilege or restriction set forth by rule, statute,
27 or legal precedent, upon written request from a licensee who, or management company which,
28 is a party to the contested case hearing. However, the Board is not required to provide any of
29 the following:

30 (1) A Board investigative report.

31 (2) The identity of a nontestifying complainant.

32 (3) Attorney-client communications, attorney work product, or other materials
33 covered by a privilege recognized by the North Carolina Rules of Civil
34 Procedure or the North Carolina Rules of Evidence.

35 (4) Any communications between the Board and its staff or among Board staff.

36 (n) The provisions of G.S. 90-29(b)(11) shall apply to this section and an individual or
37 entity shall be considered to be engaged in the practice of dentistry when obtaining or
38 exercising ownership, management, supervision, or control through or with a management
39 company or unlicensed person under a management arrangement.

40 (o) The venue for actions brought under G.S. 90-40.1 shall be the superior court of any
41 county in which acts constituting unlicensed or unlawful practice of dentistry are alleged to
42 have been committed or in which there appear reasonable grounds to believe that they will be
43 committed, in the county where at least one defendant in the action resides, or in Wake County.

44 (p) The Board shall have the power before filing a complaint and before trial to initiate
45 investigations or inquiries, conduct interviews, administer oaths, and issue subpoenas requiring
46 the attendance of persons and the production of papers and records before the Board to
47 determine whether any person or entity is or may be in violation of G.S. 90-40.1(a).

48 (q) If investigative information in the possession of the Board, its employees, or agents
49 indicates that a crime may have been committed, the Board may report the information to the
50 appropriate law enforcement agency or district attorney of the district in which the offense was
51 committed.

1 (r) The Board shall cooperate with and assist a law enforcement agency or district
2 attorney conducting a criminal investigation or prosecution of a licensee or person engaged in
3 the unauthorized practice of dentistry, including a management company, by providing
4 information that is relevant to the criminal investigation or prosecution to the investigating
5 agency or district attorney. Information disclosed by the Board to an investigative agency or
6 district attorney remains confidential and may not be disclosed by the investigating agency
7 except as necessary to further the investigation.

8 (s) The Board is authorized to conduct random audits, inspections, and investigations of
9 the management arrangements and the books and records of any management company which
10 enters into a management arrangement with a licensed dentist or professional entity, for the
11 purposes of ensuring that the management company and licensee or entity are complying with
12 this Article and rules adopted by the Board. Where the Board determines that a management
13 company or licensee is not complying with the provisions of this Article as related to a
14 management arrangement, the Board is authorized to conduct periodic audits, inspections, and
15 investigations to help ensure ongoing compliance with the provisions of this Article, to be on a
16 schedule and for a duration to be determined by the Board. In such cases, the management
17 company and licensee or entity shall be jointly responsible to reimburse the Board for the
18 reasonable costs of the periodic audits, inspections, and investigations, including the reasonable
19 costs of attorneys, accountants, or other professional consultants employed or retained by the
20 Board to conduct or assist in the process.

21 (t) The Board, in its discretion, shall be entitled to assess against the other party its
22 reasonable costs, including the Board's reasonable attorneys' fees, related to the following
23 matters:

- 24 (1) A hearing pursuant to subsection (j) of this section in which the respondent
25 is found to have violated the provisions of this Article or rules adopted by
26 the Board.
27 (2) An action for injunctive relief pursuant to G.S. 90-40.1 in which the Board
28 prevails."

29 **SECTION 2.** This act becomes effective July 1, 2011, and applies to any dentistry
30 management arrangement, as defined under G.S. 90-40.2, enacted by Section 1 of this act,
31 entered into or renewed on or after that date.



SENATE BILL 655: Dentistry Management Arrangements

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Pate, Allran
Analysis of: First Edition

Date: May 31, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 655 provides that no dentist, professional entity, or management corporation shall enter into a management arrangement unless the management arrangement meets a defined set of requirements.*

CURRENT LAW:

12 NCAC 16X.0101 currently regulates management arrangements between business entities and dentists. Management arrangements are required to be in writing and signed by all parties, to set forth all material terms of the arrangement, to describe all types of services to be provided and the time period during which those services will be provided, and to set forth the aggregate compensation to be paid. 12 NCAC 16X.0101 also outlines 8 items that no management agreement may provide for or permit.

BILL ANALYSIS:

Senate Bill 655 provides that no dentist, professional entity, or management company shall enter into a management agreement unless requirements laid out in the bill are met. Management arrangements are required to be in writing and signed by all parties, to set forth all material terms of the arrangement, to describe all types of services to be provided and the time period during which those services will be provided, and to set forth the aggregate compensation to be paid under the management arrangement. Senate Bill 655 also outlines 23 items that no management agreement shall provide for or permit.

Senate Bill 655 requires all management arrangements be submitted to the North Carolina State Board of Dental Examiners (Board). Upon submission for review, the Board shall issue a written advisory opinion concerning the compliance or noncompliance of the agreement. Any entity disagreeing with the Board's determination is granted an opportunity to request a hearing under the Administrative Procedures Act. If a management agreement is entered into prior to the Board completing its review process, the bill outlines possible action the Board may take.

Senate Bill 655 provides that any documents relating to the review of the management arrangement by the Board are not considered public records. The Board is authorized to conduct random audits, inspections, and investigations of management arrangements and the books and records of any management company which has entered into a management arrangement.

EFFECTIVE DATE:

This act is effective July 1, 2011 and applies to any dentistry management arrangement entered into or renewed on or after that date.

S655-SMTK-32(e1) v2

PAGES ATTENDING

COMMITTEE: Health Care ROOM: 1124

DATE: 6-2 TIME: ~~11:00~~ 15 mins. after session adjourns

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(4) ~~William Patterson~~	~~Greenboro~~	~~Patterson~~
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Do not add names below the grid.

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Health Care

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6-2-11

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Micaiah	NANCL
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Name of Committee

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Kristi Huff	NCH CFA
TRACY COLVARD	Attore
Katherine Ross	PRAB
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~~Sam~~	~~DATA~~
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6-1-11

Date**NAME****FIRM OR AGENCY AND ADDRESS**

Andrew Neethan
Robbman
C. GRAY

Cupstix
FLA

C. GRAY

DNA

Joseph Dero

JP Assoc.

Amy Baron

NCAC

VISITOR REGISTRATION SHEET

Health Care
Name of Committee

6-2-11
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

[illegible]

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, June 8, 2011

Room 544

The Senate Health Care Committee met on Wednesday, June 8, 2011, in Room 544 of the Legislative Office Building with Senator Louis Pate presiding.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Charles Harper, Robert Young and Dedrick Anders. He then recognized the Pages helping with the Committee: Lee Payne from Lexington and sponsored by Senator Bingham; Hannah Lee Leidy from Elizabeth City, sponsored by Senator White; Nicki Pruthi from Durham, sponsored by Senator Kinnaid; Chris Brasier also from Durham, sponsored by Senator Atwater, and Ben Hinson from Lexington, sponsored by Senator Bingham.

The first bill to be discussed was SB 770 "Birth Certificate/Stillborn Infants." Senator Brock explained the bill. Questions were asked and Senator Pate entered an amendment, after which motion was made by Senator Bingham as "Favorable as Amended." Motion carried.

SB 246 "Expand Pharmacists' Immunizing Authority" in the form of a PCS was next to be heard with Senator Hartsell explaining the bill. Senator Forrester offered an amendment, Senator Tucker moved for a "Favorable Report as Amended." Motion carried.

HB 646 "Prison Hospital Completion" was explained by Representative Dollar. Senator Atwater moved that the bill receive a "Favorable Report." The motion carried.

HB 647 "Diabetes Task Force" was explained by Rep. Dollar. Senator Tucker moved for a "Favorable Report" and motion carried.

HB 792 Committee Substitute for, "Gfeller-Waller Concussion Awareness Act" was explained by Rep. Folwell. Senator Mansfield moved for a "Favorable Report with Unfavorable to Original Bill." Motion carried.

HB 808 "Revise Laws on Adult Care Homes" was explained by Rep. Burr. Senator Meredith moved for a "Favorable Report to the Committee Substitute, Unfavorable to Original Bill." Motion carried.

Health Care Committee

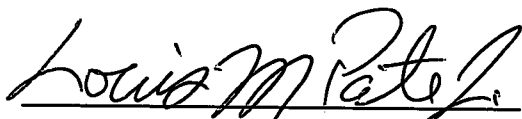
June 8, 2011

Page 2

HB 218 "Legislative Task Force on Childhood Obesity" was explained by Rep. Larry Brown. Senator Purcell offered an amendment and Senator Clary made a motion that the bill receives a "Favorable Report as Amended." Motion carried.

Having heard all the bills, the meeting adjourned at 12:00 p.m.

Respectfully Submitted,



Senator Louis M. Pate, Jr.



Edna Pearce, Committee Assistant

SENATE HEALTH CARE COMMITTEE

Wednesday, June 8, 2011

Room 544 LOB

11:00 AM

Senator Louis Pate, Presiding

AGENDA

WELCOME AND OPENING REMARKS

BILLS TO BE CONSIDERED

BILL SPONSORS

SB 246	Expand Pharmacists' Immunizing Authority	Sen. Hartsell Sen. Atwater Sen. Mansfield
HB 646	Prison Hospital Completion	Rep. Dollar
HJR 647	Diabetes Task Force	Rep. K. Alexander Rep. Bell Rep. Dollar
HB 218	Legislative Task Force on Childhood Obesity	Rep. Insko Rep. L. Brown Rep. Johnson Rep. Weiss
HB 792	Gfeller-Waller Concussion Awareness Act	Rep. Folwell Rep. Cook Rep. McGrady Rep. Glazier
HB 808	Revise Laws on Adult Care Homes	Rep. Burr
SB 770	Birth Certificate/Stillborn Infants	Sen. Brock Sen. Daniel

OTHER BUSINESS
ADJOURNMENT

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, June 08, 2011

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

FAVORABLE

H.B.	646	Prison Hospital Completion.	
		Sequential Referral:	None
		Recommended Referral:	None
H.JR.	647	Diabetes Task Force.	
		Sequential Referral:	None
		Recommended Referral:	None

FAVORABLE, AS AMENDED

S.B.	770	Birth Certificate/Stillborn Infants.	
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

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

H.B.	808	Revise Laws on Adult Care Homes.	
		Draft Number:	PCS 60075
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 4

Committee Clerk Comments:

HB 647 -- Sen. Pate
HB 646 -- Sen. Stevens
HB 808 -- Sen. Pate

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, June 08, 2011

Senator PATE,

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) 792

Gfeller-Waller Concussion Awareness Act.

Draft Number: PCS 70240

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Committee Clerk Comments:

HB 792 -- Senator Pate

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 246
PROPOSED COMMITTEE SUBSTITUTE S246-PCS85219-SQ-47

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors:

Referred to:

March 8, 2011

A BILL TO BE ENTITLED

AN ACT TO PROTECT THE PUBLIC'S HEALTH BY INCREASING ACCESS TO
IMMUNIZATIONS AND VACCINES THROUGH THE EXPANDED ROLE OF
IMMUNIZING PHARMACISTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.3 is amended by adding the following new subsection to
read:

"(i1) "Immunizing pharmacist" means a licensed pharmacist who meets all of the
following qualifications:

- (1) Holds a current provider level cardiopulmonary resuscitation certification
issued by the American Heart Association or the American Red Cross, or an
equivalent certification.
- (2) Has successfully completed a certificate program in vaccine administration
accredited by the Centers for Disease Control and Prevention, the
Accreditation Council for Pharmacy Education, or a similar health authority
or professional body approved by the Board.
- (3) Maintains documentation of three hours of continuing education every two
years, designed to maintain competency in the disease states, drugs, and
vaccine administration.
- (4) Has successfully completed training approved by the Division of Public
Health's Immunization Branch for participation in the North Carolina
Immunization Registry.
- (5) Enrolls with a local supervising health department and pays an annual
enrollment fee.
- (6) Registers with the North Carolina Board of Pharmacists as an immunizing
pharmacist.
- (7) Administers vaccines or immunizations in accordance with G.S. 90-18.15B."

SECTION 2. G.S. 90-85.3(r) reads as rewritten:

"(r) ~~"Practice of pharmacy" means the responsibility for: interpreting and evaluating
drug orders, including prescription orders; compounding, dispensing and labeling prescription
drugs and devices; properly and safely storing drugs and devices; maintaining proper records;
and controlling pharmacy goods and services. A pharmacist may advise and educate patients
and health care providers concerning therapeutic values, content, uses and significant problems
of drugs and devices; assess, record and report adverse drug and device reactions; take and~~



* S 2 4 6 - P C S 8 5 2 1 9 - S Q - 4 7 *

~~record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4, as specified in G.S. 90-85.3A."~~

SECTION 3. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.3A. Practice of pharmacy.

(a) A pharmacist is responsible for interpreting and evaluating drug orders, including prescription orders; compounding, dispensing, and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services.

(b) A pharmacist may advise and educate patients and health care providers concerning therapeutic values; content, uses, and significant problems of drugs and devices; assess, record, and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record, and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31.

(c) An immunizing pharmacist may be authorized and permitted to administer drugs as provided in G.S. 90-85.15B.

(d) A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. The rules shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(e) An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.4."

SECTION 4. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"§ 90-85.15B. Immunizing pharmacists.

(a) An immunizing pharmacist may administer vaccines or immunizations recommended or required by the Centers for Disease Control and Prevention, including vaccines recommended or required for travel outside the United States, with the following limitations:

(1) Vaccines or immunizations shall not be administered to patients under the age of 14.

(2) For patients at least 14 years of age, but less than 18 years of age, vaccines or immunizations shall be administered (i) with a specific prescription order, and (ii) at the request of the patient's parent, guardian, or person standing in loco parentis to the minor.

(3) For patients at least 14 years of age, influenza vaccines shall be administered only pursuant to protocol as provided in 21 NCAC 46 .2507 and, if the patient is less than 18 years of age, at the request of the minor's parent, guardian, or person standing in loco parentis to the minor.

(4) For patients at least 18 years of age, vaccines or immunizations shall be administered with a specific prescription order, with a standing order, or

pursuant to protocols developed by the State Health Director, in consultation with the Commission for Public Health, and implemented by rules adopted by the North Carolina Board of Pharmacy and the North Carolina Medical Board.

(b) An immunizing pharmacist who administers a vaccine or immunization to any patient pursuant to this section shall do all of the following:

- (1) Maintain a record of any vaccine or immunization administered to the patient in a patient profile.
- (2) Notify within 24 hours after administration the patient's primary care provider, if the patient has identified a primary care provider and, dependent upon the authority under which the vaccine or immunization was administered, (i) the prescribing physician, (ii) the physician who issued the standing order, or (iii) the local health department.
- (3) Access the North Carolina Immunization Registry prior to administering the vaccine or immunization and record any vaccine or immunization administered to the patient in the registry within 24 hours after administration."

SECTION 5. G.S. 130A-39(g) reads as rewritten:

"(g) A local board of health may impose a fee for services to be rendered by a local health department, except where the imposition of a fee is prohibited by statute or where an employee of the local health department is performing the services as an agent of the State. Notwithstanding any other provisions of law, a local board of health may impose cost-related fees for services performed pursuant to Article 11 of this Chapter, "Wastewater Systems," for services performed pursuant to Part 10, Article 8 of this Chapter, "Public Swimming Pools", for services performed pursuant to Part 11, Article 8 of this Chapter, "Tattooing", for services performed pursuant to G.S. 90-85.15B, and for services performed pursuant to G.S. 87-97. Fees shall be based upon a plan recommended by the local health director and approved by the local board of health and the appropriate county board or boards of commissioners. The fees collected under the authority of this subsection are to be deposited to the account of the local health department so that they may be expended for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act."

SECTION 6. G.S. 130A-153 reads as rewritten:

"(a) ~~The required immunization may be obtained from a physician licensed to practice medicine or from~~ medicine; a local health department. ~~department; or an immunizing pharmacist, in accordance with the provisions of G.S. 90-85.15B.~~ Local health departments shall administer required and State-supplied immunizations at no cost to uninsured or underinsured patients with family incomes below two hundred percent (200%) of the federal poverty level. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health departments, immunizing pharmacist, and the patient's attending physician. In addition, an insurance institution, agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may share immunization information with the Department. The Commission may, for the purpose of assisting the Department in enforcing this Part, provide by rule that other persons may have access to immunization information, in whole or in part.

(d) ~~A physician~~ physician, immunizing pharmacist, or local health department may immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to

1 the minor. A ~~physieian-physician, immunizing pharmacist,~~ or local health department may also
2 immunize a minor who is presented for immunization by an adult who signs a statement that he
3 or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to
4 obtain the immunization for the minor. Notwithstanding any other provision of this Chapter, an
5 immunizing pharmacist's authority to administer vaccines or immunizations to a minor is
6 limited to the authority specified in G.S. 90-85.15B."

7 **SECTION 7.** G.S. 130A-154(a) reads as rewritten:

8 "(a) A ~~physieian-physician, immunizing pharmacist,~~ or local health department
9 administering a required vaccine shall give a certificate of immunization to the person who
10 presented the child for immunization. The certificate shall state the name of the child, the name
11 of the child's parent, guardian, or person responsible for the child obtaining the required
12 immunization, the address of the child and the parent, guardian or responsible person, the date
13 of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the
14 doses were given, the name and address of the ~~physieian-physician, immunizing pharmacist,~~ or
15 local health department administering the required immunization and other relevant
16 information required by the Commission."

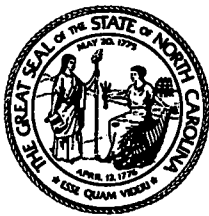
17 **SECTION 8.** 21 NCAC 46 .2507 shall govern the administration of influenza,
18 pneumococcal, and zoster vaccines by an immunizing pharmacist; provided, however, an
19 immunizing pharmacist shall be granted the authority to administer influenza vaccine to
20 patients aged 14 years and older.

21 **SECTION 9.** Not later than January 1, 2012, the State Health Director, in
22 consultation with the Commission for Public Health, shall establish standards for the
23 administration of immunizations by pharmacists in accordance with G.S. 90-85.15. The
24 standards shall include the following:

- 25 (1) Record-keeping procedures for all vaccines or immunizations administered
26 by an immunizing pharmacist.
- 27 (2) Physician accessibility to the immunizing pharmacist.
- 28 (3) A protocol establishing the oversight of the immunizing pharmacist by the
29 local health department and the process for the administration of any vaccine
30 or immunization to an individual at least 18 years of age when that vaccine
31 or immunization is administered without a specific prescription order and
32 without a standing order.
- 33 (4) A uniform protocol specific to each vaccine or immunization recommended
34 or required by the Centers for Disease Control and Prevention. The protocol
35 shall include, but not be limited to, the following:
 - 36 a. Any contraindications of the specific vaccine.
 - 37 b. Emergency procedures associated with the administration of the
38 specific vaccine.
 - 39 c. Information to be disclosed to patients regarding the specific vaccine.
 - 40 d. A procedure for annual updates on vaccine administration.

41 The North Carolina Board of Pharmacy and the North Carolina Medical Board shall adopt rules
42 to implement the standards under this section by the State Health Director in consultation with
43 the Commission for Public Health.

44 **SECTION 10.** This act becomes effective October 1, 2011.



SENATE BILL 246: Expand Pharmacists' Immunizing Authority

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S246-CSSQ-47

Date: June 8, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *The Proposed Committee Substitute to Senate Bill 246 authorizes an "immunizing pharmacist" (defined term) to administer certain vaccines or immunizations pursuant to protocols developed by the State Health Director.*

CURRENT LAW: Currently a pharmacist who has received special training is permitted to administer drugs pursuant to a specific prescription order in accordance with rules adopted by the Board of Pharmacy, Board of Nursing, and Board of Medicine.

The current rule provides standards for pharmacists engaged in the administration of influenza, pneumococcal and zoster vaccines for persons 18 years and older.

BILL ANALYSIS: Senate Bill 246 amends the Pharmacy Practice Act as follows:

Section 1 defines the term "immunizing pharmacist" as a licensed pharmacist who holds a current CPR certification, completed a certificate program in vaccine administration, maintains documentation of continuing education in vaccine administration, has successfully completed training for participation in the NC Immunization Registry, enrolls with a local supervising health department, registers with the NC Board of Pharmacy, and administers vaccines or immunizations in accordance with the Article.

Sections 2 and 3 recodify the definition of the practice of pharmacy as a new section G.S. 90-85.3A, but adds the authority for an immunizing pharmacist to administer drugs in accordance to this act.

Section 4 authorizes an immunizing pharmacist to administer vaccines or immunizations in accordance with rules and with the following limitations:

Age	Parental Permission	Standing Order	Prescription:	Under Protocol*
Under 14 Years Old	No	No	No	N/A
At Least 14 (Flu Vaccine)	<18	N/A	N/A	Current
At Least 14 < 18 Years Old (Vaccines other than Flu)	Yes, and	No	Required	
At Least 18 Years Old	N/A	Yes, or	Yes, or	Developed by SHD

Senate PCS 246

Page 2

and requires an immunizing pharmacist who administers vaccines or immunizations to do the following:

- Maintain a record of the vaccine or immunization administered in the patient profile.
- Notify the primary care provider (if the patient so identifies) within 24 hours of the administration, and notify either the prescribing physician, physician who issued standing order, or the local health department depending on which authority the vaccine was administered.
- Access the NC Immunization Registry prior to administering any vaccine or immunization and record the administration in the Registry within 24 hours of the administration.

Section 5 provides local health departments the authority to charge a fee for services performed (enrolling, oversight) pursuant to rules adopted to implement the act.

Sections 6-7 make conforming changes in the public health law to provide for an immunizing pharmacist.

Section 8 provides that the current rule governing the administration of vaccines by pharmacists remains in effect, but reduces the age of influenza vaccine recipients from 18 to 14.

Section 9 directs the State Health Director in consultation with the Commission for Public Health to establish standards for the administration of vaccines by pharmacists by January 1, 2012. The standards shall include: record keeping requirements, physician accessibility, protocols providing oversight of the immunizing pharmacist by local health departments, protocols developed per each vaccine recommended or required by the CDC including contraindications, emergency procedures, information to be disclosed to patients, a procedure for annual updates on vaccine administration. The section directs the North Carolina Board of Pharmacy to adopt rules to implement the standards.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S246-SMSQ-40(CSSQ-47) v1

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____

DATE _____

S. B. No. _____

Amendment No. _____

COMMITTEE SUBSTITUTE ☒

(to be filled in by
Principal Clerk)

Rep.) Forrester

Sen.)

1 moves to amend the bill on page 3, line 3

2 () WHICH CHANGES THE TITLE

3 by rewriting the line to read:

4 " by the North Carolina Board of Pharmacy and
5 the North Carolina Medical Board. ";

6
7 AND on page 4, line 39, by inserting
8 between the words "Pharmacy" and "the"
9 "shall" the phrase "AND the North Carolina Medical
10 Board".

11

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SIGNED

[Signature]

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

2

**HOUSE BILL 646
Corrected Copy 4/11/11**

Short Title: Prison Hospital Completion. (Public)

Sponsors: Committee on Health and Human Services (Primary Sponsor)
For a complete list of Sponsors, see Bill Information on the NCGA Web Site.

Referred to: Rules, Calendar, and Operations of the House.

April 6, 2011

A BILL TO BE ENTITLED
AN ACT TO PROVIDE FUNDING TO THE DEPARTMENT OF CORRECTION TO
COMPLETE THE CONSTRUCTION OF AN AUTHORIZED PRISON HOSPITAL.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding Section 23.12(g) of S.L. 2006-66, the Department of Correction shall take appropriate measures, including maximizing the use of the Inmate Construction Program, to reduce the costs related to the construction of projects authorized by S.L. 2007-323 and S.L. 2008-107, as each is amended by S.L. 2009-209, to be financed with the proceeds of special indebtedness incurred pursuant to Article 9 of Chapter 142 of the General Statutes. The Department of Correction, with approval of the Office of State Budget and Management, may use the proceeds of special indebtedness incurred for the original project made available by savings generated from such cost reductions, together with available funds, to provide additional funds for capital facility expenses for the completion of the Regional Medical Center and Mental Health Center in an amount not to exceed twenty million dollars (\$20,000,000). Such alternate use of funds shall not require any further approval of the Council of State pursuant to Article 9 of Chapter 142 of the General Statutes.

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



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**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

2

**HOUSE JOINT RESOLUTION 647
Corrected Copy 4/11/11**

Sponsors: Committee on Health and Human Services (Primary Sponsor)
For a complete list of Sponsors, see Bill Information on the NCGA Web Site.

Referred to: Rules, Calendar, and Operations of the House.

April 6, 2011

**A JOINT RESOLUTION TO ESTABLISH THE JOINT LEGISLATIVE TASK FORCE ON
DIABETES PREVENTION AND AWARENESS.**

Be it resolved by the House of Representatives, the Senate concurring:

SECTION 1.(a) There is established the Joint Legislative Task Force on Diabetes Prevention and Awareness (Task Force). The purpose of the Task Force is to study issues relating to diabetes awareness, treatment, and prevention with the intention of seeing measurable changes based on the work of this Task Force.

SECTION 1.(b) The Task Force shall consist of six members of the House of Representatives appointed by the Speaker of the House of Representatives and six members of the Senate appointed by the President Pro Tempore of the Senate. 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. 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. The Task Force may meet upon the joint call of the cochairs.

SECTION 1.(c) The Task Force shall study and recommend to the General Assembly strategies for addressing the problem of diabetes and issues related to it, including:

- (1) Risk factors of diabetes.
- (2) Reducing health care costs associated with diabetes.
- (3) Promoting individual wellness and healthy communities.
- (4) Increasing access to health care services.
- (5) Resolving uncoordinated care.
- (6) Increasing awareness and need of Certified Diabetes Educators.
- (7) Community initiatives and public awareness.
- (8) Promoting education of diabetes.
- (9) Any other relevant issues.

SECTION 1.(d) 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.

SECTION 1.(e) Upon the prior approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to the Task Force to aid in its work.

SECTION 1.(f) The Task Force may meet in the Legislative Building or the Legislative Office Building upon the approval of the Legislative Services Commission.



1 **SECTION 1.(g)** On or before February 1, 2013, the Task Force shall report its
2 findings and recommendations to the Governor and the 2013 General Assembly. Upon
3 submitting its final report, the Task Force shall terminate.

4 **SECTION 2.** The Legislative Services Office shall allocate funds appropriated to
5 the General Assembly to support the activities of the Task Force.

6 **SECTION 3.** This resolution is effective upon ratification.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

1

SENATE BILL 770

Short Title: Birth Certificate/Stillborn Infants. (Public)
Sponsors: Senators Brock; and Daniel.
Referred to: Health Care.

April 20, 2011

A BILL TO BE ENTITLED
AN ACT TO AUTHORIZE THE ESTABLISHMENT OF A CERTIFICATE OF BIRTH
RESULTING IN STILLBIRTH.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-114 reads as rewritten:

"§ 130A-114. Fetal death registration; certificate of birth resulting in stillbirth.

(a) Each spontaneous fetal death occurring in the State of 20 completed weeks gestation or more, as calculated from the first day of the last normal menstrual period until the day of delivery, shall be reported within 10 days after delivery to the local registrar of the county in which the delivery occurred. The report shall be made on a form prescribed and furnished by the State Registrar.

(b) When fetal death occurs in a hospital or other medical facility, the person in charge of the facility shall obtain the cause of fetal death and other required medical information over the signature of the attending physician, and shall prepare and file the report with the local registrar.

(c) When a fetal death occurs outside of a hospital or other medical facility, the physician in attendance at or immediately after the delivery shall prepare and file the report. When a fetal death is attended by a person authorized to attend childbirth, the supervising physician shall prepare and file the report. Fetal deaths attended by lay midwives and all other persons shall be treated as deaths without medical attendance as provided for in G.S. 130A-115 and the medical examiner shall prepare and file the report.

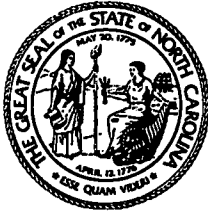
(d) For any spontaneous fetal death occurring in this State, either parent of the stillborn child may file an application with the State Registrar requesting a certificate of birth resulting in stillbirth. The certificate of birth resulting in stillbirth (i) shall be based upon the information available from the fetal death report filed pursuant to this section, (ii) shall not include any reference to the name of the stillborn child if the fetal death report does not include the name of the stillborn child and the parent filing the application does not elect to provide a name, and (iii) shall clearly indicate that it is not proof of a live birth. If the spontaneous fetal death occurred in this State prior to July 1, 2002, the State Registrar may not issue a certificate of birth resulting in stillbirth unless the application for the certificate is accompanied by a certified copy of the fetal death report. Issuance of a certificate of birth resulting in stillbirth does not replace the requirement to file a report of fetal death under this section.

SECTION 2. The Department of Health and Human Services shall use funds available to the Department to implement the provisions of this act.

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



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SENATE BILL 770: Birth Certificate/Stillborn Infants

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Brock
Analysis of: First Edition

Date: June 7, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *Senate Bill 770 authorizes the establishment of a certificate of birth resulting in stillbirth.*

CURRENT LAW: Each spontaneous fetal death of 20 completed or more weeks gestation that occurs in this State is required to be reported to a local county registrar in accordance with G.S. 130A-114 on forms prescribed and furnished by the State Registrar.

The Vital Records Section of the Division of Public Health is authorized to administer the statewide vital records program outlined in Article 4 of Chapter 130A of the North Carolina General Statutes.

BILL ANALYSIS: Senate Bill 770 would amend G.S. 130A-114 to permit either parent of a stillborn child to file an application with the State Registrar to obtain a certificate of birth resulting in stillbirth (certificate). The bill provides the certificate shall be based on the fetal death report and shall clearly indicate that it is not a proof of live birth. Further the certificate shall not include a reference to the name of the stillborn child if the fetal death report does not contain a name and the parent filing the application does not elect to provide a name.

The State Registrar is prohibited from issuing a certificate for deaths occurring prior to July 1, 2002, without a certified copy of the fetal death report.

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

BACKGROUND: Currently 28 states have enacted legislation to provide for a certificate of birth resulting in stillbirth. (www.missingangelsbill.org accessed June 7, 2011)

S770-SMSQ-39(e1) v1



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 770

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

S770-ASQ-79 [v.1]

Page 1 of 1

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____, 2011

Senator _____

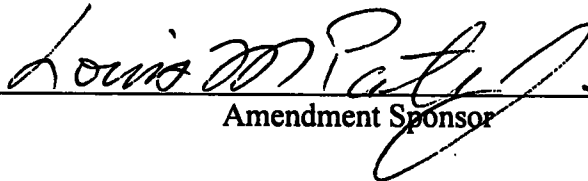
1 moves to amend the bill on page 1, lines 29-32, by deleting the following sentence:

2
3 "If the spontaneous fetal death occurred in this State prior to July 1, 2002, the State Registrar
4 may not issue a certificate of birth resulting in stillbirth unless the application for the certificate
5 is accompanied by a certified copy of the fetal death report."; and
6

7 on line 36, by rewriting the line to read:

8
9 "SECTION 3. This act is effective October 1, 2011, and applies to spontaneous
0 fetal deaths that occur in this State on or after October 1, 2011."

SIGNED


Amendment Sponsor

SIGNED

Committee Chair if Senate Committee Amendment

ADOPTED

FAILED

TABLED



* S 7 7 0 - A S Q - 7 9 - V - 1 *

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

2

**HOUSE BILL 792
Committee Substitute Favorable 4/20/11**

Short Title: Gfeller-Waller Concussion Awareness Act. (Public)

Sponsors:

Referred to:

April 7, 2011

A BILL TO BE ENTITLED
AN ACT TO ENACT THE GFELLER-WALLER CONCUSSION AWARENESS ACT.
The General Assembly of North Carolina enacts:

TITLE OF ACT.

SECTION 1. This act may be known and cited as the Gfeller-Waller Concussion Awareness Act.

DEVELOPMENT OF AN ATHLETIC CONCUSSION SAFETY TRAINING PROGRAM.

SECTION 2.(a) The Matthew A. Gfeller Sport-Related Traumatic Brain Injury Research Center at UNC-Chapel Hill in consultation with the North Carolina Medical Society, the North Carolina Athletic Trainers Association, the Brain Injury Association of North Carolina, the North Carolina Neuropsychological Society, the North Carolina High School Athletic Association, Inc., and the Department of Public Instruction shall develop an athletic concussion safety training program. The program shall be developed for the use of coaches, school nurses, school athletic directors, volunteers, students who participate in interscholastic athletic activities in the public schools, and the parents of these students.

SECTION 2.(b) The program shall include, but not be limited to, the following:

- (1) Written information detailing the recognition of the signs and symptoms of concussions and other head injuries.
- (2) A description of the physiology and the potential short-term and long-term effects of concussions and other head injuries.
- (3) The medical return-to-play protocol for postconcussion participation in interscholastic athletic activities.

CONCUSSION SAFETY REQUIREMENTS FOR INTERSCHOLASTIC ATHLETIC COMPETITION.

SECTION 3. G.S. 115C-12(23) reads as rewritten:

"(23) Power to Adopt Eligibility Rules for Interscholastic Athletic Competition. – The State Board of Education ~~may~~shall adopt rules governing interscholastic athletic activities conducted by local boards of education, including eligibility for student participation. With regard to middle schools and high schools, the rules shall provide for the following:

- a. All coaches, school nurses, athletic directors, first responders, volunteers, students who participate in interscholastic athletic activities, and the parents of those students shall receive, on an



* H 7 9 2 - V - 2 *

1 annual basis, a concussion and head injury information sheet. School
2 employees, first responders, volunteers, and students must sign the
3 sheet and return it to the coach before they can participate in
4 interscholastic athletic activities, including tryouts, practices, or
5 competition. Parents must sign the sheet and return it to the coach
6 before their children can participate in any such interscholastic
7 athletic activities. The signed sheets shall be maintained in
8 accordance with sub-subdivision d. of this subdivision.

9 For the purpose of this subdivision, a concussion is a traumatic
10 brain injury caused by a direct or indirect impact to the head that
11 results in disruption of normal brain function, which may or may not
12 result in loss of consciousness.

13 b. If a student participating in an interscholastic athletic activity
14 exhibits signs or symptoms consistent with concussion, the student
15 shall be removed from the activity at that time and shall not be
16 allowed to return to play or practice that day. The student shall not
17 return to play or practice on a subsequent day until the student is
18 evaluated by and receives written clearance for such participation
19 from (i) a licensed medical physician with training in concussion
20 management or (ii) one of the following health care providers who
21 has training in concussion management and is working in
22 consultation with a medical physician: a neuropsychologist, a
23 licensed athletic trainer, a licensed physician assistant, or a licensed
24 nurse practitioner.

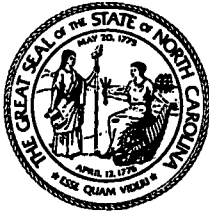
25 c. Each school shall develop a venue specific emergency action plan to
26 deal with serious injuries and acute medical conditions in which the
27 condition of the patient may deteriorate rapidly. The plan shall
28 include a delineation of roles, methods of communication, available
29 emergency equipment, and access to and plan for emergency
30 transport. This plan must be (i) in writing, (ii) reviewed by an athletic
31 trainer licensed in North Carolina, (iii) approved by the principal of
32 the school, (iv) distributed to all appropriate personnel, (v) posted
33 conspicuously at all venues, and (vi) reviewed and rehearsed
34 annually by all licensed athletic trainers, first responders, coaches,
35 school nurses, athletic directors, and volunteers for interscholastic
36 athletic activities.

37 d. Each school shall maintain complete and accurate records of its
38 compliance with the requirements of this subdivision pertaining to
39 head injuries.

40 The State Board of Education may authorize a designated organization to
41 apply and enforce the Board's rules governing participation in interscholastic
42 athletic activities at the high school level."

43
44 **EFFECTIVE DATE.**

45 **SECTION 4.** This act is effective when it becomes law and applies beginning with
46 the 2011-2012 school year.



HOUSE BILL 792: Gfeller-Waller Concussion Awareness Act

2011-2012 General Assembly

Committee:	Senate Health Care	Date:	June 7, 2011
Introduced by:	Reps. Folwell, Cook, McGrady, Glazier	Prepared by:	Amy Jo Johnson
Analysis of:	PCS to Second Edition H792-CSTK-28		Committee Counsel

SUMMARY: *The PCS to House Bill 792 requires the development of an athletic concussion safety training program and directs the State Board of Education's (SBE) rules governing middle and high school interscholastic athletic activities to create new requirements surrounding interscholastic athletic activities.*

CURRENT LAW: G.S. 115C-12(23) states that the SBE may adopt rules governing interscholastic athletic activities conducted by local boards of education, including eligibility for student participation. The SBE may authorize a designated organization to apply and enforce these rules at the high school level.

BILL ANALYSIS: House Bill 792 directs the Matthew A. Gfeller Sport-Related Traumatic Brain Injury Research Center at UNC-Chapel Hill, in cooperation with various athletic and brain injury-related associations, to develop an athletic concussion safety training program. This program would be used by coaches and other school-related personnel, volunteers, students and parents who are involved in public school athletic activities.

The bill amends G.S. 115-12(23) by requiring the SBE to adopt rules governing interscholastic athletic activities conducted by local boards of education. The bill requires the rules for middle and high school interscholastic athletic activities to include the following:

- Annual dissemination of a "concussion and head injury information sheet" to all persons involved in athletic activities such as school personnel, volunteers, first responders, students and their parents.
- Return to the coach of a signed "concussion and head injury information sheet" by school personnel, first responders, volunteers, students and their parents before participating in interscholastic athletic activities,
- Removal of students exhibiting signs and symptoms consistent with concussion from the activity. Students would not be allowed to return to play or practice until evaluated by, and in receipt of, written clearance from medical personnel with training in concussion management. *The PCS makes technical changes to the professionals who are able to provide this written clearance.*
- Development of written school emergency action plans for dealing with serious injuries and acute medical conditions. The plan must be reviewed by a North Carolina licensed athletic trainer, approved by the school's principal, distributed to all appropriate personnel, posted conspicuously at all venues, and annually reviewed and rehearsed by all personnel involved with extracurricular athletic activities,
- Maintenance of complete and accurate records of compliance with these requirements.

EFFECTIVE DATE: This bill would become effective when it becomes law and would apply beginning with 2011-2012 school year.

Patsy Pierce, Legislative Analyst, substantially contributed to this summary

H792-SMTK-42(CSTK-28) v3

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

D

**HOUSE BILL 792
Committee Substitute Favorable 4/20/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H792-CSTK-28 [v.2]**

6/7/2011 4:10:03 PM

Short Title: Gfeller-Waller Concussion Awareness Act. (Public)

Sponsors:

Referred to:

April 7, 2011

**A BILL TO BE ENTITLED
AN ACT TO ENACT THE GFELLER-WALLER CONCUSSION AWARENESS ACT.**
The General Assembly of North Carolina enacts:

TITLE OF ACT.

SECTION 1. This act may be known and cited as the Gfeller-Waller Concussion Awareness Act.

DEVELOPMENT OF AN ATHLETIC CONCUSSION SAFETY TRAINING PROGRAM.

SECTION 2.(a) The Matthew A. Gfeller Sport-Related Traumatic Brain Injury Research Center at UNC-Chapel Hill in consultation with the North Carolina Medical Society, the North Carolina Athletic Trainers Association, the Brain Injury Association of North Carolina, the North Carolina Neuropsychological Society, the North Carolina High School Athletic Association, Inc., and the Department of Public Instruction shall develop an athletic concussion safety training program. The program shall be developed for the use of coaches, school nurses, school athletic directors, volunteers, students who participate in interscholastic athletic activities in the public schools, and the parents of these students.

SECTION 2.(b) The program shall include, but not be limited to, the following:

- (1) Written information detailing the recognition of the signs and symptoms of concussions and other head injuries.
- (2) A description of the physiology and the potential short-term and long-term effects of concussions and other head injuries.
- (3) The medical return-to-play protocol for postconcussion participation in interscholastic athletic activities.

CONCUSSION SAFETY REQUIREMENTS FOR INTERSCHOLASTIC ATHLETIC COMPETITION.

SECTION 3. G.S. 115C-12(23) reads as rewritten:

"(23) Power to Adopt Eligibility Rules for Interscholastic Athletic Competition. – The State Board of Education ~~may~~shall adopt rules governing interscholastic athletic activities conducted by local boards of education,



1 including eligibility for student participation. With regard to middle schools
2 and high schools, the rules shall provide for the following:

3 a. All coaches, school nurses, athletic directors, first responders,
4 volunteers, students who participate in interscholastic athletic
5 activities, and the parents of those students shall receive, on an
6 annual basis, a concussion and head injury information sheet. School
7 employees, first responders, volunteers, and students must sign the
8 sheet and return it to the coach before they can participate in
9 interscholastic athletic activities, including tryouts, practices, or
10 competition. Parents must sign the sheet and return it to the coach
11 before their children can participate in any such interscholastic
12 athletic activities. The signed sheets shall be maintained in
13 accordance with sub-subdivision d. of this subdivision.

14 For the purpose of this subdivision, a concussion is a traumatic
15 brain injury caused by a direct or indirect impact to the head that
16 results in disruption of normal brain function, which may or may not
17 result in loss of consciousness.

18 b. If a student participating in an interscholastic athletic activity
19 exhibits signs or symptoms consistent with concussion, the student
20 shall be removed from the activity at that time and shall not be
21 allowed to return to play or practice that day. The student shall not
22 return to play or practice on a subsequent day until the student is
23 evaluated by and receives written clearance for such participation
24 from: (i) a physician licensed under Article 1, Chapter 90 of the
25 General Statutes with training in concussion management, (ii) a
26 neuropsychologist licensed under 18A, Chapter 90 of the General
27 Statutes with training in concussion management and working in
28 consultation with a physician licensed under Article 1, Chapter 90 of
29 the General Statutes, (iii) an athletic trainer licensed under Article 34,
30 Chapter 90 of the General Statutes, (iv) a physician assistant,
31 consistent with the limitations of G.S. 90-18.1, or (v) a nurse
32 practitioner, consistent with the limitations of G.S. 90-18.2.

33 c. Each school shall develop a venue specific emergency action plan to
34 deal with serious injuries and acute medical conditions in which the
35 condition of the patient may deteriorate rapidly. The plan shall
36 include a delineation of roles, methods of communication, available
37 emergency equipment, and access to and plan for emergency
38 transport. This plan must be (i) in writing, (ii) reviewed by an athletic
39 trainer licensed in North Carolina, (iii) approved by the principal of
40 the school, (iv) distributed to all appropriate personnel, (v) posted
41 conspicuously at all venues, and (vi) reviewed and rehearsed
42 annually by all licensed athletic trainers, first responders, coaches,
43 school nurses, athletic directors, and volunteers for interscholastic
44 athletic activities.

45 d. Each school shall maintain complete and accurate records of its
46 compliance with the requirements of this subdivision pertaining to
47 head injuries.

48 The State Board of Education may authorize a designated organization to
49 apply and enforce the Board's rules governing participation in interscholastic
50 athletic activities at the high school level."

EFFECTIVE DATE.

SECTION 4. This act is effective when it becomes law and applies beginning with the 2011-2012 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

D

HOUSE BILL 808
Second Edition Engrossed 5/2/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H808-PCS60075-SH-28

Short Title: Revise Laws on Adult Care Homes.

(Public)

Sponsors:

Referred to:

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DIVISION OF HEALTH SERVICE REGULATION, TO WAIVE ANNUAL
INSPECTIONS OF ADULT CARE HOMES THAT ACHIEVE THE HIGHEST RATING,
AND TO DEVELOP AN INFORMAL DISPUTE RESOLUTION PROCEDURE THAT
ALLOWS ADULT CARE HOMES TO DISPUTE CITED INSPECTION
DEFICIENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. The Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. 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."

SECTION 2. G.S. 131D-2.11 is amended by adding two new subsections to read:

"(a1) Waiver of Annual State Inspection. – The Division of Health Service Regulation may waive the annual inspection requirement under subsection (a) of this section for any adult care home that has achieved the highest rating in accordance with rules adopted by the North Carolina Medical Care Commission pursuant to G.S. 131D-10. However, at least once every two years the Division of Health Service Regulation shall inspect any adult care home for which the annual inspection requirement was waived.

(a2) Informal Dispute Resolution. –

(1) The Division of Health Service Regulation shall offer each adult care home an opportunity, at the facility's request and upon the facility's receipt of the official statement of deficiencies, to informally resolve disputed findings from inspections conducted by the Division of Health Service Regulation in accordance with this section.

(2) Failure of the Division of Health Service Regulation to complete informal dispute resolution timely does not delay the effective date of any



1 enforcement action taken by the Division of Health Service Regulation
2 against an adult care home.

3 (3) An adult care home is not entitled to seek a delay of any enforcement action
4 against it on the grounds that the Division of Health Service Regulation has
5 not completed informal dispute resolution prior to the effective date of the
6 enforcement action.

7 (4) If an adult care home successfully demonstrates during informal dispute
8 resolution that any of the deficiencies cited in the official statement of
9 deficiencies should not have been cited, the Division of Health Service
10 Regulation shall remove the incorrectly cited deficiencies from the official
11 statement of deficiencies and rescind any enforcement actions imposed on
12 the adult care home solely as a result of the incorrectly cited deficiencies.

13 (5) Upon request, the Division of Health Service Regulation shall provide an
14 adult care home with written notification of these informal dispute resolution
15 procedures."

16 **SECTION 3.** This act becomes effective October 1, 2011.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

1

HOUSE BILL 218*

Short Title: Legislative Task Force on Childhood Obesity. (Public)

Sponsors: Representatives Insko, L. Brown, Johnson, and Weiss (Primary Sponsors).
For a complete list of Sponsors, see Bill Information on the NCGA Web Site.

Referred to: Rules, Calendar, and Operations of the House.

March 3, 2011

A BILL TO BE ENTITLED
AN ACT TO ESTABLISH THE LEGISLATIVE TASK FORCE ON CHILDHOOD
OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. There is created the Legislative Task Force on Childhood Obesity.

SECTION 2. The Task Force shall consist of 12 members as follows:

- (1) Six members appointed by the Speaker of the House of Representatives.
- (2) Six members appointed by the President Pro Tempore of the Senate.

SECTION 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. 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 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 the following:

- (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.
- (9) Other means.

SECTION 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 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 any time



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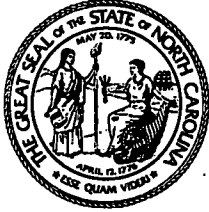
1 upon the joint call of the cochairs. The Task Force may meet in the Legislative Building or the
2 Legislative Office Building.

3 With approval of the Legislative Services Commission, the Legislative Services
4 Officer shall assign professional staff to assist the Task Force in its work. The House of
5 Representatives' and the Senate's Directors of Legislative Assistants shall assign clerical staff to
6 the Task Force, and the expenses relating to the clerical employees shall be borne by the Task
7 Force. The Task Force may contract for professional, clerical, or consultant services as
8 provided by G.S. 120-32.02. If the Task Force hires a consultant, the consultant shall not be a
9 State employee or a person currently under contract with the State to provide services.

10 All State departments and agencies and local governments and their subdivisions
11 shall furnish the Task Force with any information in their possession or available to them.

12 **SECTION 7.** The Task Force shall submit a final report of the results of its study
13 and its recommendations to the 2012 Regular Session of the 2011 General Assembly. The Task
14 Force shall terminate on May 1, 2012, or upon the filing of its final report, whichever occurs
15 first.

16 **SECTION 8.** This act is effective when it becomes law.



HOUSE BILL 218: Legislative Task Force on Childhood Obesity

2011-2012 General Assembly

Committee:	Senate Health Care	Date:	June 7, 2011
Introduced by:	Reps. Insko, L. Brown, Johnson, Weiss	Prepared by:	Susan Barham
Analysis of:	First Edition		Research Assistant

SUMMARY: *House Bill 218 would establish the Legislative Task Force on Childhood Obesity.*

[As introduced, this bill was identical to S242, as introduced by Sens. Purcell, Preston, Tillman, which is currently in Rules and Operations of the Senate.]

BILL ANALYSIS:

House Bill 218 would create 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 may meet upon the call of the cochairs. Task Force members would receive per diem, subsistence and travel allowances as authorized by statute. Funds to support the Task Force would be allocated by the Legislative Services Office. The Task Force may contract for professional, clerical, or consultant services, but the consultant must not be a State employee or a person currently under contract with the State to provide services.

The bill would direct the Task Force 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.

House Bill would provide that the Legislative Task Force on Childhood Obesity must submit a report to the 2012 Regular Session of the 2011 General Assembly. The Task Force must terminate on May 1, 2012, or upon filing its final report, whichever occurs first.

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

H218-SMTE-12(e1) v1

AGENDA

SENATE HEALTH CARE COMMITTEE

June 8, 2011

SENATOR LOUIS M. PATE, JR. PRESIDING

CALL TO ORDER

WELCOME MEMBERS AND GUEST

RECOGNIZE: SGTS. AT ARMS:

Charles Harper
Robert Young
Dedrick Akkers

<u>PAGES</u>	<u>FROM</u>	<u>SPONSOR</u>
<u>Chris Brasier Jr</u>	<u>Durham</u>	<u>Sen Otwater</u>
<u>Lee Payne</u>	<u>Lexington</u>	<u>Sen Bingham</u>
<u>Hannah Lidy</u>	<u>Elizabeth City</u>	<u>Sen White</u>
<u>Nicki Prutki</u>	<u>Durham</u>	<u>Sen Kinnaird</u>
<u>Ben Hinson</u>	<u>Lexington</u>	<u>Sen Bingham</u>
_____	_____	_____
_____	_____	_____

(Edna) 106
Sen. Pate

PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 6-8 TIME: 11 AM & 15 min.s. after Session

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
① Lee Payne	Lexington	Bingham
②		
③ Hannah Lee Leidy	Elizabeth City	White
④ Nick Pruthi	Durham	Kinnaird
⑤ Chris Brasier	Durham	Atwater
⑥ Ben Hinson	Lexington	Bingham
7		
8		
9		
10		

Do not add names below the grid.

VISITOR REGISTRATION SHEET

Health Committee

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shawn Chase	Brain Injury Assoc. of NC
Heather Barnett	Williams Mullen
W. Gordon Phipps	DLC + Assoc
Meghan Malka	Advocates for Health in Action
Emily Kujawa	Advocates for Health in Action
Butch Gunnells	NC Beverage Assoc
Morgan Norris	NCAP
Leah Elliott	intern
John Costopoulos	Am. Heart Assoc.
Kyle Haney	NC Democratic Party
Thomas Sinodis	UNC-Eshelman School of Pharmacy
Sara Riggins	NCFPC

VISITOR REGISTRATION SHEET

Health Committee

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Elise Bouchard

Sen. Bingham

Dr. Lettie J. Glenn

Independent Consultant

Michelle Moody

NASW-NC

Kay Patsy

NASW-NC

Bob Conder

NORTH CAROLINA
DEVELOPMENTAL PSYCHOLOGICAL SOCIETY

Vickie Pearce

DHHS -DPH

Dr. Kasey A. Joun

NC Pediatric Society

Holly Saffi

DRNC

Amy McConkey

NC Pediatrics

John Mahan

ASMC

VISITOR REGISTRATION SHEET

Health Committee

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Maan Goff

Smith Anderson

Matthew Eisle

Smith Anderson

Jimmy Broughton

Wendole Carlyle

Prince Counseling

student

Barbara Carlson

BECOL

Alan Skipper

NCM 5

Paige Barefoot

Rep. Folwell

Reston Jones

Rep. Folwell

VISITOR REGISTRATION SHEET

Health Committee

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Allison Waller

Nelson Mullins

Lauren Phillips

Wakemed

Janna Fonsecc

North Carolina Athletic
Trainers Assoc.

Josiah Brown

Carolina FP + Sports Medicine

Rep. Dore Fowles

Speake - Pro - Team NCHHS

VISITOR REGISTRATION SHEET

Health Committee

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Faulk	NCSBA
Meredith Swindle	The Policy Group
Mary Bock	AHIP
CSH/HS	SS
Robin Plerson	NCRSA
Lin Water	NCHETC-T
Bill Risti	Ag, D
Susie Shah	NCPHA
Bill Stovall	NIC DGC
Abby Enen	NMSS-NC
Hunt Hargy	NMSS-NC

VISITOR REGISTRATION SHEET

Health Committee

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rachel House	NMSS-NC
Charles Hicks	Representative Murry's Office
John Morant	Policy Group
Joyce Peters	JP Assoc
Debbie Ragan	NC Physical Therapy Association
Karen Lambert	Bodies in Balance Physical Therapy
Karen McCulloch	UNC - Chapel Hill
Mike Jones	ACP
Angela L	NCAHA
Alissa Willett	NCAAC
John Devlin	Governor's Office

SENATE HEALTH CARE COMMITTEE

June 8, 2011

MINUTES

The Senate Health Care Committee met on Wednesday, June 8, 2011 in Room 1124 of the Legislative Building. Eleven members were in attendance along with staff Shawn Parker, Theresa Matula, Amy Jo Johnson, and Susan Barham.

Senator Bingham called the meeting to order at 8:47pm. Senator Pate made a motion to consider Proposed Committee Substitute S597 AN ACT TO ENSURE THAT THE BEHAVIORAL HEALTH NEEDS OF MEMBERS OF THE MILITARY, VETERANS, AND THEIR FAMILIES ARE MET (attached). The motion carried and the bill's sponsor, Senator Purcell explained the bill. Shawn Parker of the Fiscal Research Staff explained the appropriation implications of the bill. After questions and discussion, Senator Pate made a motion for a favorable report. The motion carried and the report was unfavorable as to bill, but favorable as to committee substitute bill.

The next bill considered was the Proposed Committee Substitute 696 AN ACT TO DIRECT THE GENERAL ADMINISTRATION OF THE UNIVERSITY OF NORTH CAROLINA TO STUDY WAYS TO INCREASE PRIMARY CARE RESIDENCIES IN UNDERSERVED AREAS OF NORTH CAROLINA (attached). The motion to consider carried and the bill's sponsor, Senator Stein, explained the bill. Senator Blake stated that the Campbell Medical School will open in two years. After questions and discussion, Senator Robinson made a motion for a favorable report. The motion carried and the report was unfavorable as to bill, but favorable as to committee substitute bill.

The next bill considered was the Proposed Committee Substitute 697 AN ACT PROHIBITING RETALIATION AGAINST ANY NURSE WHO MAKES A GOOD FAITH REPORT CONCERNING PATIENT MEDICAL CARE (attached). The motion to consider carried and the bill's sponsor, Senator Stein, explained the bill. Theresa Matula of the Fiscal Research Staff explained the intricacies of the bill. After questions and discussion, Senator Mansfield made a motion for a favorable report. The motion carried and the report was unfavorable as to bill, but favorable as to committee substitute bill.

Senator Bingham called on Senator Kinnaird to explain her bill S508 AN ACT TO CLARIFY THE APPLICABILITY OF MEDICAL AND RELIGIOUS VACCINE EXEMPTIONS TO THE NORTH CAROLINA EMERGENCY MANAGEMENT ACT (attached). After discussion and questions, Senator Clary made a motion for a favorable report. The motion carried and the report was favorable as to the bill.

The next bill to be considered was Representative Lewis' bill, Committee Substitute H397 AN ACT REVISING PENALTIES AND REMEDIES CONCERNING HEALTH FACILITIES (attached). Jesse Goodman of the NC Dept. of Health and Human Services explained the bill. After discussion and questions, Senator Clary made a motion for a favorable report. The motion

carried and the report was favorable as to Committee Substitute bill with a sequential referral to the Senate Finance Committee.

The last bill considered was Representative Hurley's bill, H509 AN ACT TO EXCLUDE FROM LICENSURE AS A FACILITY CONSUMERS LIVING IN THEIR OWN HOME AND RECEIVING SERVICES (attached). Jesse Goodman of the NC Dept. of Health and Human Services explained the bill. After discussion and questions, Senator Robinson made a motion for a favorable report. The motion carried and the report was favorable as to the bill.

The meeting was adjourned at 9:25pm.

Respectfully submitted,



Maria Kinnaird, Committee Assistant


Senator Stan Bingham, Presiding Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Principal Clerk _____
Reading Clerk _____

Corrected:

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 8, 2011	15 Min. after Session	1124

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 696	Address Primary Care Shortage.	Senator Stein
SB 697	Patient Advocacy & Protection Act.	Senator Stein
SB 717	Photo I.D. For SNAP Recipients.	Senator Mansfield
SB 508	Clarify Vaccine Exemptions/Emerg. Mgmt Act.	Senator Kinnaird
SB 597	Behavioral Health Services for Military/Funds.	Senator Purcell
HB 397	DHHS Penalties and Remedies Revision.-AB	Representative Lewis
HB 509	Exclusions from Licensure: Home Services.	Representative Hurley

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

Senate Health Care Committee
Wednesday, June 8, 2011, 15 min. after Session
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 508	Clarify Vaccine Exemptions/Emerg. Mgmt Act.	Senator Kinnaird
SB 696	Address Primary Care Shortage.	Senator Stein
SB 697	Patient Advocacy & Protection Act.	Senator Stein
SB 717	Photo I.D. For SNAP Recipients.	Senator Mansfield
HB 397	DHHS Penalties and Remedies Revision.-AB	Representative Lewis
HB 509	Exclusions from Licensure: Home Services.	Representative Hurley

Other Business

Adjournment

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Wednesday, June 08, 2011

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

FAVORABLE

S.B.	508	Clarify Vaccine Exemptions/Emerg. Mgmt Act.
		Sequential Referral: None
		Recommended Referral: None
H.B.(CS #1)	397	DHHS Penalties and Remedies Revision.-AB
		Sequential Referral:
		Recommended Referral: None
H.B.	509	Exclusions from Licensure: Home Services.
		Sequential Referral: None
		Recommended Referral: None

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

S.B.	597	Behavioral Health Services for Military/Funds.
		Draft Number: pcs85220
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: No
S.B.	696	Address Primary Care Shortage.
		Draft Number: pcs85221
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: Yes
S.B.	697	Patient Advocacy & Protection Act.
		Draft Number: pcs15181
		Sequential Referral: None
		Recommended Referral: None
		Long Title Amended: Yes

TOTAL REPORTED: 6

Committee Clerk Comments:

Senator L. Pate will speak on HB509

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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D

**SENATE BILL 597*
PROPOSED COMMITTEE SUBSTITUTE S597-PCS85220-LE-20**

Short Title: Behavioral Health Services for Military.

(Public)

Sponsors:

Referred to:

April 14, 2011

..... A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT THE BEHAVIORAL HEALTH NEEDS OF MEMBERS OF
THE MILITARY, VETERANS, AND THEIR FAMILIES ARE MET.

The General Assembly of North Carolina enacts:

SECTION 1.(a) To the extent feasible and practicable, State and local agencies who provide services directed at individuals who have served in the active or reserve components of the Armed Forces of the United States and their families shall make personnel and other resources available to the National Guard Family Assistance Centers.

SECTION 1.(b) The Department of Crime Control and Public Safety shall report annually to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Justice and Public Safety and to the House of Representatives Committee on Homeland Security, Military, and Veterans Affairs on the activities of the National Guard Family Assistance Centers. This report shall include information on services provided as well as on the number and type of members of the active or reserve components of the Armed Forces of the United States, veterans, and family members served.

SECTION 2.(a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall collaborate with military agencies and other appropriate organizations to determine gaps in the care of current and former members of the reserve or active components of the Armed Forces of the United States with traumatic brain injury, shall develop recommendations for an accessible community-based neurobehavioral system of care for those service members, and shall report its recommendations by July 1, 2012, to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Health and Human Services and Justice and Public Safety, to the Chairs of the House of Representatives Committee on Homeland Security, Military, and Veterans Affairs, and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The recommendations shall be tailored so that, if implemented, services would be available to service members, veterans, and their families and would consist of neurobehavioral programs, residential programs, comprehensive day programs, and home-based programs.

SECTION 2.(b) The Division of Medical Assistance of the Department of Health and Human Services, MedSolutions, Inc., and the appropriate health professionals at the United States Department of Veterans Affairs shall work together to ensure that MedSolutions, Inc., is



1 using the appropriate evidence-based diagnostic testing (including imaging, biomarker testing,
2 and other tests) for screening and assessment of traumatic brain injury.

3 **SECTION 3.(a)** The North Carolina Area Health Education Centers (AHEC)
4 Program shall facilitate and continue to provide health education and skills training for health
5 professional students; primary care, mental health, and substance abuse service providers; and
6 hospital administrators about the health, mental health, and substance abuse needs of the
7 military and their families. This training shall include information about the following:

- 8 (1) The number of North Carolinians who are serving or who have served in the
9 active or reserve components of the Armed Forces of the United States.
- 10 (2) Military culture.
- 11 (3) The average number of deployments, length of time in conflict zones, and
12 potential injuries these members may have faced, particularly those who
13 have served recently in Iraq or Afghanistan.
- 14 (4) The types of health, mental health, and substance abuse disorders that
15 service personnel may have experienced, including traumatic brain injury
16 (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST),
17 depression, substance use disorders, potential suicide risks, or domestic
18 violence.
- 19 (5) The potential impact of the deployment cycle on family members and
20 children. This information shall include information about resiliency skills,
21 intervention skills, resources, and community supports.
- 22 (6) Evidence-based screening and assessment instruments.
- 23 (7) Evidence-based case management, treatment, and medication management
24 for different mental health and substance abuse problems, and potential
25 adverse effects of prescribed medications, particularly for people with
26 comorbidities.
- 27 (8) Information about the TRICARE system, payment, and enrollment
28 procedures.
- 29 (9) Available referral sources through TRICARE, the United States Department
30 of Veterans Affairs, Military One Source, Army One Source, Defense
31 Centers of Excellence, Deployment Health Clinical Center, the North
32 Carolina National Guard's Integrated Behavioral Health System, Local
33 Management Entities, the North Carolina Department of Health and Human
34 Services (DHHS) Office of Citizen Services, North Carolina Health Info,
35 Federally Qualified Health Centers, professional advocacy and support
36 services, and other community resources.

37 **SECTION 3.(b)** In carrying out the requirements of Section 3(a) of this act, the
38 AHEC Program shall collaborate with the Citizen Soldier Support Program; North Carolina
39 health professional training programs; the United States Department of Veterans Affairs; the
40 North Carolina Division of Veterans Affairs; The University of North Carolina; Operation
41 Re-Entry North Carolina; the North Carolina Community College System; health care
42 professional associations; the Division of Mental Health, Developmental Disabilities, and
43 Substance Abuse Services; Governor's Focus on Servicemembers, Veterans, and Their
44 Families; and academic health programs.

45 **SECTION 4.(a)** The Division of Mental Health, Developmental Disabilities, and
46 Substance Abuse Services of the Department of Health and Human Services shall, together
47 with the Division of Medical Assistance of the Department of Health and Human Services,
48 explore the possibility of implementing value-based purchasing or grants that would provide
49 additional reimbursement to providers who:

- 50 (1) Complete approved training programs that focus on the identification,
51 treatment, and referral of members of the reserve or active components of

the Armed Forces of the United States, veterans, and their families who may have experienced depression, traumatic brain injury, posttraumatic stress disorder, military sexual trauma, substance use disorders, potential suicide risks, or domestic violence.

(2) Consistently use State-approved, evidence-based screening and assessment instruments to identify people with one or more of the conditions described in subdivision (1) of this subsection.

(3) Consistently offer evidence-based treatment, including medication management and psychotherapy.

(4) Report the process and outcome measures recommended pursuant to Section 4(b) of this act.

(5) Actively participate in TRICARE; the United States Department of Veterans Affairs fee-for-service system; programs of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; and Medicaid.

SECTION 4.(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance, in collaboration with the United States Department of Veterans Affairs, shall define appropriate behavioral health process and outcome measures on which to tie performance-based incentive payments. These shall be included in the report required by Section 4(c) of this act.

SECTION 4.(c) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall report its recommendations by July 1, 2012, to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Health and Human Services, to the Chairs of the House of Representatives Committee on Homeland Security, Military, and Veterans Affairs, and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 5. The North Carolina Office of Rural Health and Community Care of the Department of Health and Human Services, in conjunction with the North Carolina Foundation for Advanced Health Programs through the Center of Excellence in Integrated Care, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Governor's Institute on Substance Abuse, North Carolina Community Care Networks, Inc., the North Carolina Community Health Center Association, and other professional associations, shall work to expand the collocation in primary care practices serving the adult population of licensed health professionals trained in providing mental health and substance abuse services.

SECTION 6. G.S. 122C-115.4 is amended by adding a new subsection to read:

"(g) The Commission shall adopt rules to ensure that the needs of members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members are met by requiring:

(1) Each LME to have at least one trained care coordination person on staff to serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the North Carolina Department of Correction, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.

(2) LME staff members who provide screening, triage, or referral services to receive training to enhance the services provided to members of the active or reserve components of the Armed Forces of the United States, veterans, and

1 their families. The training required by this subdivision shall include training
2 on at least all of the following:

3 a. The number of persons who serve or who have served in the active or
4 reserve components of the Armed Forces of the United States in the
5 LME's catchment area.

6 b. The types of mental health and substance abuse disorders that these
7 service personnel and their families may have experienced, including
8 traumatic brain injury, posttraumatic stress disorder, depression,
9 substance use disorders, potential suicide risks, military sexual
10 trauma, and domestic violence.

11 c. Appropriate resources to which these service personnel and their
12 families may be referred as needed."

13 **SECTION 7.(a)** The University of North Carolina, the North Carolina Community
14 Colleges System Office, and other institutions of higher education in this State shall, in
15 conjunction with the Area Health Education Center of The University of North Carolina and
16 the Governor's Institute on Substance Abuse, seek and apply for federal grants that may be
17 available to expand mental health and substance abuse training opportunities in this State in
18 order to increase the number of mental health and substance abuse providers in this State.

19 **SECTION 7.(b)** On or before July 1, 2012, the Board of Governors of The
20 University of North Carolina shall report to the Joint Legislative Health Care Oversight
21 Committee, the House of Representatives and Senate Appropriations Subcommittees on Health
22 and Human Services, and the House of Representatives Committee on Homeland Security,
23 Military, and Veterans Affairs on the amount of funds obtained pursuant to Section 7(a) of this
24 act. This report shall also include recommendations about whether those are sufficient to meet
25 the following goals or whether additional support from the General Fund is needed:

26 (1) To ensure that the curriculum of public and private institutions of higher
27 education in this State includes information that educates health
28 professionals about the unique behavioral health needs of the active duty and
29 reserve components of the Armed Forces of the United States and their
30 families.

31 (2) To provide grants to people seeking knowledge or training related to the
32 provision of mental health or substance abuse services at public or private
33 institutions of higher education in this State or who are undertaking the
34 hours of supervised training needed in order to obtain a license in one of
35 these fields. Priority shall be given to individuals who have served in the
36 active or reserve components of the Armed Forces of the United States or
37 who are willing to work with such individuals and their families.

38 **SECTION 7.(c)** Each institution of higher education in this State shall provide to
39 the Board of Governors any information the Board requires in order to comply with the
40 reporting requirement of Section 7(b) of this act.

41 **SECTION 8.(a)** The Division of Mental Health, Developmental Disabilities, and
42 Substance Abuse Services of the Department of Health and Human Services shall, in
43 conjunction with the Citizen Soldier Support Program, the Governor's Focus on
44 Servicemembers, Veterans, and Their Families, the North Carolina Division of Veterans
45 Affairs, the United States Department of Veterans Affairs, and other appropriate organizations,
46 develop a training curriculum to be targeted at the following types of organizations:

47 (1) Crisis workers, including mental health and addiction services staff on
48 mobile crisis teams; screening, triage, and referral (STR) teams; public
49 safety officers; crisis intervention teams (CITs); emergency management
50 technicians (EMTs); disaster and emergency response teams; local sheriffs'
51 offices; and local Red Cross chapters.

- (2) Veterans service organizations and veterans service officers.
- (3) Professional advocacy and support organizations, including the National Alliance on Mental Illness North Carolina, the Traumatic Brain Injury Association of North Carolina, and other nonprofit organizations that have a mission to serve members of the active duty and reserve components, veteran members of the military, and their families.
- (4) Military chaplains.

SECTION 8.(b) The training curriculum shall include information about the following core issues:

- (1) The types of mental health and substance abuse disorders that service personnel and their families may have experienced, including traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST), depression, substance use disorder (SUD), potential suicide risks, or domestic violence.
- (2) Strategies to encourage eligible veterans to enroll in and access services through the VA system, including opportunities to enroll former military members with previously undiagnosed PTSD, MST, TBI, or SUD, and those who left under less than honorable discharges into the VA system, if the reason for the discharge was due to behavioral health problems that arose or were exacerbated through military service.
- (3) Available referral sources through TRICARE, the United States Department of Veterans Affairs, Military One Source, Army One Source, Defense Centers of Excellence, Deployment Health Clinical Center, the North Carolina National Guard's Integrated Behavioral Health System, Local Management Entities, the North Carolina Department of Health and Human Services (DHHS) Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, and other community resources.

SECTION 8.(c) That portion of the training curriculum directed towards crisis workers, professional advocacy and support organizations, and faith communities shall include information about the following:

- (1) The number of North Carolinians who are serving or who have served in the active or reserve components of the Armed Forces of the United States.
- (2) Military culture.
- (3) The average number of deployments, length of time in conflict zones, and potential injuries these members may have faced, particularly those who have served recently in Iraq or Afghanistan.
- (4) The potential impact of the deployment cycle on family members and children. This information shall include information about resiliency skills, intervention skills, resources, and community supports, with a focus on the critical role of the faith community in the provision of assistance with needed service, personal support, and, when necessary, grief counseling.
- (5) Early identification of individual or family members with mental health or substance abuse disorders and appropriate referral sources.

SECTION 8.(d) On or before July 1, 2012, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall report on the curriculum developed pursuant to this section to the Joint Legislative Health Care Oversight Committee, the House of Representatives and Senate Appropriations Subcommittees on Health and Human Services, and the House of Representatives Committee on Homeland Security, Military, and Veterans Affairs.

SECTION 9.(a) G.S. 115C-47 is amended by adding a new subdivision to read:

"(60) To Ensure That the Unique Needs of Students With Immediate Family Members in the Military Are Met. – Local boards of education shall collect and annually report to the State Board of Education the following information for each school in the local school administrative unit:

- a. The number of students who have an immediate family member who has served in the reserve or active components of the Armed Forces of the United States since September 1, 2011.
- b. Whether during the relevant period the local school administrative unit employed at least one employee trained in the unique needs of children who have immediate family members in the military. An employee satisfies this requirement if the employee has received training on all of the following:
 1. The number of children of members of the active or reserve components of the Armed Forces of the United States who live in the local school administrative unit.
 2. Available curricula on military families.
 3. The impact of deployments on the emotional and psychological well-being of the children and families.
 4. Potential warning signs of emotional and mental health disorders, substance use disorders, suicide risks, child maltreatment, or domestic violence.
 5. Appropriate resources to which students and their families may be referred as needed.
 6. Scholarships for after-school and enrichment activities available through the United States Department of Defense, the National Guard, or the reserve components of the Armed Forces of the United States for the children of parents who are actively deployed.
- c. The frequency with which the employee described in sub-subdivision b. of this subdivision provided training to school administrators, nurses, nurse aides, counselors, social workers, and other personnel in the local school administrative unit during the relevant period, and the number of staff trained."

SECTION 9.(b) G.S. 115C-12 is amended by adding a new subdivision to read:

"(38) Duty to Report Certain Information Regarding Students With Immediate Family Members in the Military. – The State Board of Education shall submit an annual report no later than March 15 of each year to the Joint Legislative Education Oversight Committee and to the House of Representatives and Senate Appropriations Subcommittees on Education containing the information relating to the needs of students with immediate family members in the military submitted to it pursuant to G.S. 115C-47(60)."

SECTION 10.(a) The General Administration of The University of North Carolina, in collaboration with Operation Re-Entry North Carolina at East Carolina University, North Carolina Translational and Clinical Sciences Institute, other institutions of higher education in this State, the North Carolina National Guard, and the United States Department of Veterans Affairs, shall, to the extent available resources allow, collaborate on research to address the behavioral health problems and challenges facing military personnel, veterans, and their families.

SECTION 10.(b) The research required by this section shall be conducted by collaborative research teams which shall include civilian investigators from institutions of

1 higher learning in this State and private research organizations, health providers in regional and
2 national military health system institutions, and providers and investigators in VISN 6 in the
3 VA system. These teams shall aggressively pursue federal funding to conduct the research
4 required by this section.

5 **SECTION 10.(c)** At a minimum, the research required by this section shall include
6 the following goals:

- 7 (1) To define the behavioral health problems facing service members, veterans,
8 and their families, with a special emphasis on the behavioral health needs of
9 the reserve components of the Armed Forces of the United States, including
10 the National Guard.
- 11 (2) To develop, implement, and evaluate innovative pilot programs to improve
12 the quality, accessibility, and delivery of behavioral health services provided
13 to this population.
- 14 (3) To evaluate the effectiveness of new programs put into place by the National
15 Guard and other military organizations to address the behavioral health
16 challenges facing military service personnel, veterans, and family members.
17 The National Guard shall cooperate in providing information to assess the
18 effectiveness of behavioral health services provided to it and its members.
- 19 (4) To contribute to the knowledge of evidence-based behavioral health
20 screening, diagnosis, treatment, and recovery supports for military service
21 personnel, veterans, and their families.
- 22 (5) To study other issues pursuant to requests by the various branches of the
23 active and reserve components of the Armed Forces of the United States and
24 the United States Department of Veterans Affairs, in order to improve
25 behavioral health services for service members, veterans, and their families.

26 **SECTION 10.(d)** On July 1, 2012, and annually thereafter, the General
27 Administration of The University of North Carolina shall report its findings to the Joint
28 Legislative Health Care Oversight Committee and to the House of Representatives and Senate
29 Appropriations Subcommittees on Health and Human Services.

30 **SECTION 11.** Section 9 of this act becomes effective October 1, 2011. The
31 remainder of this act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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SENATE BILL 597*

Short Title: Behavioral Health Services for Military/Funds. (Public)

Sponsors: Senators Purcell; Atwater and Mansfield.

Referred to: Appropriations/Base Budget.

April 14, 2011

A BILL TO BE ENTITLED

**AN ACT TO ENSURE THAT THE BEHAVIORAL HEALTH NEEDS OF MEMBERS OF
THE MILITARY, VETERANS, AND THEIR FAMILIES ARE MET.**

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is appropriated from the General Fund to the Department of Crime Control and Public Safety the sum of one million four hundred seventy thousand dollars (\$1,470,000) for the 2011-2012 fiscal year and the sum of one million four hundred seventy thousand dollars (\$1,470,000) for the 2012-2013 fiscal year to establish and support the following positions at each of the National Guard's seven Family Assistance Centers:

(1) A mental health and substance abuse counselor.

(2) A behavioral health case manager.

(3) A veteran outreach peer specialist.

SECTION 1.(b) The positions established pursuant to Section 1(a) of this act shall be used to sustain and enhance the North Carolina National Guard Integrated Behavioral Health System. While the System currently serves all persons who have served in the active or reserve components of the Armed Forces of the United States and their families, priority shall be given to individuals who are not eligible for, or who have difficulty accessing, United States Department of Veterans Affairs services or TRICARE.

SECTION 1.(c) To the extent feasible and practicable, State and local agencies who provide services directed at individuals who have served in the active or reserve components of the Armed Forces of the United States and their families shall make personnel and other resources available to the National Guard Family Assistance Centers.

SECTION 1.(d) The funds appropriated in Section 1(a) of this act may also be used to do the following:

(1) Foster communication between trained mental health, substance abuse, and behavioral health counselors and psychiatrists or other licensed professionals who can provide to persons served by the North Carolina National Guard Integrated Behavioral Health System medication management or other health services that are needed in order to address more significant health problems.

(2) Enhance the use of telepsychiatry in rural areas to expand the availability of psychiatric services for active duty and retired members of the active and reserve components of the Armed Forces of the United States, veterans, and their families.

SECTION 1.(e) The Department of Crime Control and Public Safety shall report annually to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Justice and Public Safety and to the House of Representatives Committee on



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1 Homeland Security, Military, and Veterans Affairs on the activities of the National Guard
2 Family Assistance Centers. This report shall include information on services provided as well
3 as on the number and type of members of the active or reserve components of the Armed
4 Forces of the United States, veterans, and family members served.

5 **SECTION 2.(a)** The Division of Mental Health, Developmental Disabilities, and
6 Substance Abuse Services of the Department of Health and Human Services shall collaborate
7 with military agencies and other appropriate organizations to determine gaps in the care of
8 current and former members of the reserve or active components of the Armed Forces of the
9 United States with traumatic brain injury, shall develop recommendations for an accessible
10 community-based neurobehavioral system of care for those service members, and shall report
11 its recommendations by July 1, 2012, to the Chairs of the House of Representatives and Senate
12 Appropriations Subcommittees on Health and Human Services and Justice and Public Safety,
13 to the Chairs of the House of Representatives Committee on Homeland Security, Military, and
14 Veterans Affairs, and to the Joint Legislative Oversight Committee on Mental Health,
15 Developmental Disabilities, and Substance Abuse Services. The recommendations shall be
16 tailored so that if implemented, services would be available to service members, veterans, and
17 their families and would consist of neurobehavioral programs, residential programs,
18 comprehensive day programs, and home-based programs.

19 **SECTION 2.(b)** The Division of Medical Assistance of the Department of Health
20 and Human Services, MedSolutions, Inc., and the appropriate health professionals at the United
21 States Department of Veterans Affairs shall work together to ensure that MedSolutions, Inc., is
22 using the appropriate evidence-based diagnostic testing (including imaging, biomarker testing,
23 and other tests) for screening and assessment of traumatic brain injury.

24 **SECTION 3.(a)** The North Carolina Area Health Education Centers (AHEC)
25 Program shall facilitate and continue to provide health education and skills training for health
26 professional students; primary care, mental health, and substance abuse service providers; and
27 hospital administrators about the health, mental health, and substance abuse needs of the
28 military and their families. This training shall include information about the following:

- 29 (1) The number of North Carolinians who are serving or who have served in the
30 active or reserve components of the Armed Forces of the United States.
- 31 (2) Military culture.
- 32 (3) The average number of deployments, length of time in conflict zones, and
33 potential injuries these members may have faced, particularly those who
34 have served recently in Iraq or Afghanistan.
- 35 (4) The types of health, mental health, and substance abuse disorders that
36 service personnel may have experienced, including traumatic brain injury
37 (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST),
38 depression, substance use disorders, potential suicide risks, or domestic
39 violence.
- 40 (5) The potential impact of the deployment cycle on family members and
41 children. This information shall include information about resiliency skills,
42 intervention skills, resources, and community supports.
- 43 (6) Evidence-based screening and assessment instruments.
- 44 (7) Evidence-based case management, treatment, and medication management
45 for different mental health and substance abuse problems, and potential
46 adverse effects of prescribed medications, particularly for people with
47 comorbidities.
- 48 (8) Information about the TRICARE system, payment, and enrollment
49 procedures.
- 50 (9) Available referral sources through TRICARE, the United States Department
51 of Veterans Affairs, Military One Source, Army One Source, Defense

Centers of Excellence, Deployment Health Clinical Center, the North Carolina National Guard's Integrated Behavioral Health System, Local Management Entities, the North Carolina Department of Health and Human Services (DHHS) Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, and other community resources.

SECTION 3.(b) In carrying out the requirements of Section 3(a) of this act, the AHEC Program shall collaborate with the Citizen Soldier Support Program; North Carolina health professional training programs; the United States Department of Veterans Affairs; the North Carolina Division of Veterans Affairs; The University of North Carolina; Operation Re-Entry North Carolina; the North Carolina Community College System; health care professional associations; the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Governor's Focus on Servicemembers, Veterans, and Their Families; and academic health programs.

SECTION 3.(c) There is appropriated from the General Fund to the Area Health Education Centers (AHEC) Program the sum of two hundred fifty thousand dollars (\$250,000) for the 2011-2012 fiscal year to develop additional continuing education conferences, workshops, and online courses that present the information described in subdivisions (6) through (9) of Section 3(a) of this act. These funds may also be used to adapt existing curricula that address clinical care and evidence-based treatments for brain injury, behavioral health, and substance abuse problems to reflect the special needs of service personnel.

SECTION 4.(a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall, together with the Division of Medical Assistance of the Department of Health and Human Services, explore the possibility of implementing value-based purchasing or grants that would provide additional reimbursement to providers who:

- (1) Complete approved training programs that focus on the identification, treatment, and referral of members of the reserve or active components of the Armed Forces of the United States, veterans, and their families who may have experienced depression, traumatic brain injury, posttraumatic stress disorder, military sexual trauma, substance use disorders, potential suicide risks, or domestic violence.
- (2) Consistently use State-approved evidence-based screening and assessment instruments to identify people with one or more of the conditions described in subdivision (1) of this subsection.
- (3) Consistently offer evidence-based treatment, including medication management and psychotherapy.
- (4) Report the process and outcome measures recommended pursuant to Section 4(b) of this act.
- (5) Actively participate in TRICARE, the United States Department of Veterans Affairs fee-for-service system, programs of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and Medicaid.

SECTION 4.(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance, in collaboration with the United States Department of Veterans Affairs, shall define appropriate behavioral health process and outcome measures on which to tie performance-based incentive payments. These shall be included in the report required by Section 4(c) of this act.

SECTION 4.(c) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall report its recommendations by July 1, 2012, to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Health and Human Services, to the Chairs of the House of Representatives Committee on Homeland Security,

1 Military, and Veterans Affairs, and to the Joint Legislative Oversight Committee on Mental
2 Health, Developmental Disabilities, and Substance Abuse Services.

3 **SECTION 5.(a)** The North Carolina Office of Rural Health and Community Care
4 of the Department of Health and Human Services, in conjunction with the North Carolina
5 Foundation for Advanced Health Programs through the Center of Excellence in Integrated
6 Care, the Division of Mental Health, Developmental Disabilities, and Substance Abuse
7 Services, the Governor's Institute on Substance Abuse, North Carolina Community Care
8 Networks, Inc., the North Carolina Community Health Center Association, and other
9 professional associations, shall work to expand the collocation in primary care practices serving
10 the adult population of licensed health professionals trained in providing mental health and
11 substance abuse services.

12 **SECTION 5.(b)** There is appropriated from the General Fund to the North
13 Carolina Office of Rural Health and Community Care of the Department of Health and Human
14 Services the sum of five hundred thousand dollars (\$500,000) for the 2011-2012 fiscal year and
15 the sum of five hundred thousand dollars (\$500,000) for the 2012-2013 fiscal year to do the
16 following:

- 17 (1) Provide grants to support the start-up costs of collocating licensed substance
18 abuse and mental health professionals in primary care practices.
- 19 (2) Provide grants to support the continuing education of mental health and
20 substance abuse professionals who are already colocated in an existing
21 primary care practice in order to cross-train these professionals to provide
22 mental health or substance abuse services to TRICARE, Medicaid, and
23 uninsured patients with substance abuse disorders.

24 **SECTION 5.(c)** Funds appropriated in Section 5(b) of this act shall be targeted to
25 private practices, Federally Qualified Health Centers, local health departments, and rural health
26 clinics that are located in counties with, or that serve, a substantial number of active or former
27 members of the military and their families, that are enrolled providers in TRICARE, and that
28 participate in Community Care of North Carolina.

29 **SECTION 6.** There is appropriated from the General Fund to the North Carolina
30 Department of Health and Services the sum of one hundred twenty-eight thousand five hundred
31 two dollars (\$128,502) for the 2011-2012 fiscal year and the sum of one hundred twenty-eight
32 thousand five hundred two dollars (\$128,502) for the 2012-2013 fiscal year to expand
33 CARE-LINE in order to ensure the competency and capacity to handle crisis calls, including
34 potential suicides, in a timely manner, and to ensure that telephone counselors are available 24
35 hours a day, seven days a week, and 365 days a year.

36 **SECTION 7.** G.S. 122C-115.4 is amended by adding a new subsection to read:

37 "(g) The Commission shall adopt rules to ensure that the needs of members of the active
38 and reserve components of the Armed Forces of the United States, veterans, and their family
39 members are met by requiring:

- 40 (1) Each LME to have at least one trained care coordination person on staff to
41 serve as the point of contact for TRICARE, the North Carolina National
42 Guard's Integrated Behavioral Health System, the Army Reserve Department
43 of Psychological Health, the United States Department of Veterans Affairs,
44 the North Carolina Department of Correction, and related organizations to
45 ensure that members of the active and reserve components of the Armed
46 Forces of the United States, veterans, and their family members have access
47 to State-funded services when they are not eligible for federally funded
48 mental health or substance abuse services.
- 49 (2) LME staff members who provide screening, triage, or referral services to
50 receive training to enhance the services provided to members of the active or
51 reserve components of the Armed Forces of the United States, veterans, and

1 their families. The training required by this subdivision shall include training
2 on at least all of the following:

3 a. The number of persons who serve or who have served in the active or
4 reserve components of the Armed Forces of the United States in the
5 LME's catchment area.

6 b. The types of mental health and substance abuse disorders that these
7 service personnel and their families may have experienced, including
8 traumatic brain injury, posttraumatic stress disorder, depression,
9 substance use disorders, potential suicide risks, military sexual
10 trauma, and domestic violence.

11 c. Appropriate resources to which these service personnel and their
12 families may be referred as needed."

13 **SECTION 8.(a)** The University of North Carolina, the North Carolina Community
14 Colleges System Office, and other institutions of higher education in this State shall, in
15 conjunction with the Area Health Education Center of The University of North Carolina and
16 the Governor's Institute on Substance Abuse, seek and apply for federal grants that may be
17 available to expand mental health and substance abuse training opportunities in this State in
18 order to increase the number of mental health and substance abuse providers in this State.

19 **SECTION 8.(b)** On or before July 1, 2012, the Board of Governors of The
20 University of North Carolina shall report to the Joint Legislative Health Care Oversight
21 Committee, the House of Representatives and Senate Appropriations Subcommittees on Health
22 and Human Services, and the House of Representatives Committee on Homeland Security,
23 Military, and Veterans Affairs on the amount of funds obtained pursuant to Section 8(a) of this
24 act. This report shall also include recommendations about whether those are sufficient to meet
25 the following goals or whether additional support from the General Fund is needed:

26 (1) To ensure that the curriculum of public and private institutions of higher
27 education in this State includes information that educates health
28 professionals about the unique behavioral health needs of the active duty and
29 reserve components of the Armed Forces of the United States and their
30 families.

31 (2) To provide grants to people seeking knowledge or training related to the
32 provision of mental health or substance abuse services at public or private
33 institutions of higher education in this State or who are undertaking the
34 hours of supervised training needed in order to obtain a license in one of
35 these fields. Priority shall be given to individuals who have served in the
36 active or reserve components of the Armed Forces of the United States or
37 who are willing to work with such individuals and their families.

38 **SECTION 8.(c)** Each institution of higher education in this State shall provide to
39 the Board of Governors any information the Board requires in order to comply with the
40 reporting requirement of Section 8(b) of this act.

41 **SECTION 9.(a)** The Division of Mental Health, Developmental Disabilities, and
42 Substance Abuse Services of the Department of Health and Human Services shall, in
43 conjunction with the Citizen Soldier Support Program, the Governor's Focus on
44 Servicemembers, Veterans, and Their Families, the North Carolina Division of Veterans
45 Affairs, the United States Department of Veterans Affairs, and other appropriate organizations,
46 develop a training curriculum to be targeted at the following types of organizations:

47 (1) Crisis workers, including mental health and addiction services staff on
48 mobile crisis teams; screening, triage, and referral (STR) teams; public
49 safety officers; crisis intervention teams (CITs); emergency management
50 technicians (EMTs); disaster and emergency response teams; local sheriffs'
51 offices; and local Red Cross chapters.

(2) Veterans service organizations and veterans service officers.

(3) Professional advocacy and support organizations, including the National Alliance on Mental Illness North Carolina, the Traumatic Brain Injury Association of North Carolina, and other nonprofit organizations that have a mission to serve members of the active duty and reserve components, veteran members of the military, and their families.

(4) Military chaplains.

SECTION 9.(b) The training curriculum shall include information about the following core issues:

(1) The types of mental health and substance abuse disorders that service personnel and their families may have experienced, including traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST), depression, substance use disorder (SUD), potential suicide risks, or domestic violence.

(2) Strategies to encourage eligible veterans to enroll in and access services through the VA system, including opportunities to enroll former military members with previously undiagnosed PTSD, MST, TBI, or SUD, and those who left under less than honorable discharges into the VA system, if the reason for the discharge was due to behavioral health problems that arose or were exacerbated through military service.

(3) Available referral sources through TRICARE, the United States Department of Veterans Affairs, Military One Source, Army One Source, Defense Centers of Excellence, Deployment Health Clinical Center, the North Carolina National Guard's Integrated Behavioral Health System, Local Management Entities, the North Carolina Department of Health and Human Services (DHHS) Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, and other community resources.

SECTION 9.(c) That portion of the training curriculum directed towards crisis workers, professional advocacy and support organizations, and faith communities shall include information about the following:

(1) The number of North Carolinians who are serving or who have served in the active or reserve components of the Armed Forces of the United States.

(2) Military culture.

(3) The average number of deployments, length of time in conflict zones, and potential injuries these members may have faced, particularly those who have served recently in Iraq or Afghanistan.

(4) The potential impact of the deployment cycle on family members and children. This information shall include information about resiliency skills, intervention skills, resources, and community supports, with a focus on the critical role of the faith community in the provision of assistance with needed service, personal support, and when necessary, grief counseling.

(5) Early identification of individual or family members with mental health or substance abuse disorders and appropriate referral sources.

SECTION 9.(d) On or before July 1, 2012, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall report on the curriculum developed pursuant to this section to the Joint Legislative Health Care Oversight Committee, the House of Representatives and Senate Appropriations Subcommittees on Health and Human Services, and the House of Representatives Committee on Homeland Security, Military, and Veterans Affairs.

SECTION 10.(a) G.S. 115C-47 is amended by adding a new subdivision to read:

1 "(60) To Ensure That the Unique Needs of Students with Immediate Family
2 Members in the Military Are Met. – Local boards of education shall collect
3 and annually report to the State Board of Education the following
4 information for each school in the local school administrative unit:

5 a. The number of students who have an immediate family member who
6 has served in the reserve or active components of the Armed Forces
7 of the United States since September 1, 2011.

8 b. Whether during the relevant period the local school administrative
9 unit employed at least one employee trained in the unique needs of
10 children who have immediate family members in the military. An
11 employee satisfies this requirement if the employee has received
12 training on all of the following:

13 1. The number of children of members of the active or reserve
14 components of the Armed Forces of the United States who
15 live in the local school administrative unit.

16 2. Available curricula on military families.

17 3. The impact of deployments on the emotional and
18 psychological well-being of the children and families.

19 4. Potential warning signs of emotional and mental health
20 disorders, substance use disorders, suicide risks, child
21 maltreatment, or domestic violence.

22 5. Appropriate resources to which students and their families
23 may be referred as needed.

24 6. Scholarships for after-school and enrichment activities
25 available through the United States Department of Defense,
26 the National Guard, or the reserve components of the Armed
27 Forces of the United States, for the children of parents who
28 are actively deployed.

29 c. The frequency with which the employee described in sub-subdivision
30 b. of this subdivision provided training to school administrators,
31 nurses, nurse aides, counselors, social workers, and other personnel
32 in the local school administrative unit during the relevant period; and
33 the number of staff trained."

34 **SECTION 10.(b)** G.S. 115C-12 is amended by adding a new subdivision to read:

35 "(38) Duty to Report Certain Information Regarding Students With Immediate
36 Family Members in the Military. – The State Board of Education shall
37 submit an annual report no later than March 15 of each year to the Joint
38 Legislative Education Oversight Committee and to the House of
39 Representatives and Senate Appropriations Subcommittees on Education
40 containing the information relating to the needs of students with immediate
41 family members in the military submitted to it pursuant to
42 G.S. 115C-47(60)."

43 **SECTION 11.(a)** The General Administration of The University of North
44 Carolina, in collaboration with Operation Re-Entry North Carolina at East Carolina University,
45 North Carolina Translational and Clinical Sciences Institute, other institutions of higher
46 education in this State, the North Carolina National Guard, and the United States Department of
47 Veterans Affairs, shall, to the extent available resources allow, collaborate on research to
48 address the behavioral health problems and challenges facing military personnel, veterans, and
49 their families.

50 **SECTION 11.(b)** The research required by this section shall be conducted by
51 collaborative research teams which shall include civilian investigators from institutions of

1 higher learning in this State and private research organizations, health providers in regional and
2 national military health system institutions, and providers and investigators in VISN 6 in the
3 VA system. These teams shall aggressively pursue federal funding to conduct the research
4 required by this section.

5 **SECTION 11.(c)** At a minimum, the research required by this section shall include
6 the following goals:

- 7 (1) To define the behavioral health problems facing service members, veterans,
8 and their families, with a special emphasis on the behavioral health needs of
9 the reserve components of the Armed Forces of the United States, including
10 the National Guard.
- 11 (2) To develop, implement, and evaluate innovative pilot programs to improve
12 the quality, accessibility, and delivery of behavioral health services provided
13 to this population.
- 14 (3) To evaluate the effectiveness of new programs put into place by the National
15 Guard and other military organizations to address the behavioral health
16 challenges facing military service personnel, veterans, and family members.
17 The National Guard shall cooperate in providing information to assess the
18 effectiveness of behavioral health services provided to it and its members.
- 19 (4) To contribute to the knowledge of evidence-based behavioral health
20 screening, diagnosis, treatment, and recovery supports for military service
21 personnel, veterans, and their families.
- 22 (5) To study other issues pursuant to requests by the various branches of the
23 active and reserve components of the Armed Forces of the United States and
24 the United States Department of Veterans Affairs, in order to improve
25 behavioral health services for service members, veterans, and their families.

26 **SECTION 11.(d)** On July 1, 2012, and annually thereafter, the General
27 Administration of The University of North Carolina shall report its findings to the Joint
28 Legislative Health Care Oversight Committee and to the House of Representatives and Senate
29 Appropriations Subcommittees on Health and Human Services.

30 **SECTION 12.** Sections 1, 5, and 6 of this act become effective July 1, 2011.
31 Section 10 becomes effective October 1, 2011. The remainder of this act is effective when it
32 becomes law.



SENATE BILL 696: Address Primary Care Shortage

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Stein
Analysis of: First Edition

Date: June 8, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate bill 696 directs the General Administration of the University of North Carolina to study and make recommendations on an appropriate structure and methodology to increase the number of primary care residencies in underserved areas of North Carolina.*

BILL ANALYSIS: Senate Bill 696 would direct the General Administration of the University of North Carolina to study and make recommendations regarding increasing the number of primary care residencies in underserved areas of the North Carolina. The bill requires the following participants to be involved in the study:

- Charlotte Mecklenburg Hospital Authority
- East Carolina University Brody School of Medicine
- University of North Carolina at Chapel Hill School of Medicine
- Wake Forest University of Medicine
- North Carolina Hospital Association
- Old North State Medical Society
- North Carolina Medical Society

The study will include an assessment of the State's need for healthcare providers, strategies to increase the supply of physicians, priorities in regards to what physicians specialties are most needed, recommendation of pilot projects, identification of innovative training methods, consideration of ways to encourage more physicians to practice in North Carolina, strategies for increasing minorities in the medical field, consideration of scholarships for residents who make a commitment to stay and practice in the State, and recommendations for methods to engage academic medical centers and Area Health Education Center sites to expand their residency training programs.

The General Administration of the University of North Carolina will report its findings and any recommended legislation to the Joint Legislative Health Care Oversight Committee on or before April 1, 2012.

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

S696-SMTK-47(e1) v2

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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**SENATE BILL 696
PROPOSED COMMITTEE SUBSTITUTE S696-CSTK-31 [v.2]**

6/8/2011 5:19:40 PM

Short Title: Address Primary Care Shortage.

(Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

**AN ACT TO DIRECT THE GENERAL ADMINISTRATION OF THE UNIVERSITY OF
NORTH CAROLINA TO STUDY WAYS TO INCREASE PRIMARY CARE
RESIDENCIES IN UNDERSERVED AREAS OF NORTH CAROLINA.**

The General Assembly of North Carolina enacts:

SECTION 1.(a) The General Administration of The University of North Carolina, in collaboration with academic medical centers and medical associations throughout the State, shall study and make recommendations on an appropriate structure and methodology to increase the number of primary care residencies in underserved areas of North Carolina.

SECTION 1.(b) The study shall include participation by the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System; Duke University and Health System; East Carolina University Brody School of Medicine; University of North Carolina at Chapel Hill School of Medicine; Wake Forest University of Medicine; the North Carolina Hospital Association; the Old North State Medical Society; and the North Carolina Medical Society.

SECTION 1.(c) The study shall include, but is not limited to, the following:

- (1) An assessment of the State's healthcare needs specifically, but not limited to, the need for healthcare providers, on an ongoing basis.
- (2) The development of strategies to increase the overall supply of physicians to meet current and future unmet health needs of the State's growing population.
- (3) A recommendation that the allocation of any new funds allocated for new Graduated Medical Education (GME) positions from the State Legislature to address physician workforce issues facing the State.
- (4) Establishment of priorities for which types of physician specialties are most needed to meet the healthcare needs of the State.
- (5) A recommendation to develop and oversee the implementation of pilot demonstration projects directed at increasing supply of graduate institutions.
- (6) The identification of programs that develop innovative training methods and strategies.
- (7) The consideration of ways to encourage more physicians to train and to practice in North Carolina including underserved areas by working with the



1 academic medical centers to develop new training models to expand the
2 number of physicians training in rural North Carolina.

3 (8) The development of strategies for implementation of policies to help
4 increase the representation of currently underrepresented minorities in the
5 medical field.

6 (9) The identification of barriers that affect recruitment into GME slots and
7 retention of physicians following residency and ways to address those
8 barriers.

9 (10) The consideration of the development of scholarships for North Carolina
10 residents going to North Carolina medical schools who make a commitment
11 to stay and practice in the State.

12 (11) Recommendations for methods to engage academic medical centers and
13 Area Health Education Center sites with respect to the short and long-term
14 expansion capacities of their residency training programs.

15 (12) The development of metrics that demonstrate success of these initiatives and
16 in meeting the goals for the corporation.

17 **SECTION 2.** The General Administration of the University of North Carolina shall
18 report its findings and any recommended legislation to the Joint Legislative Health Care
19 Oversight Committee on or before April 1, 2012.

20 **SECTION 3.** This act is effective when it becomes law.
21

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

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SENATE BILL 696

Short Title: Address Primary Care Shortage. (Public)

Sponsors: Senator Stein.

Referred to: Appropriations/Base Budget.

April 20, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ADDRESS PRIMARY CARE PHYSICIAN SHORTAGES IN NORTH
3 CAROLINA BY MODIFYING THE ENROLLMENT CHANGE FUNDING MODEL
4 AND THE BOARD OF GOVERNORS' MEDICAL SCHOLARSHIP LOAN PROGRAM.

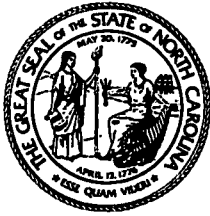
5 The General Assembly of North Carolina enacts:

6 **SECTION 1.** The General Administration of The University of North Carolina
7 shall modify the existing student credit hour enrollment change funding model as it applies to
8 the Brody School of Medicine at East Carolina University and the UNC-Chapel Hill School of
9 Medicine. The revised model shall include a performance-based funding component to
10 incorporate performance indicators, including the percentage of graduates entering primary care
11 specialties.

12 **SECTION 2.** The Board of Governors of The University of North Carolina shall
13 include in its criteria for awarding scholarship loans under G.S. 116-40.9 a candidate's
14 preference in professional practice area and shall reserve one or more Program slots to
15 individuals who will specialize in primary care.

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





SENATE BILL 697: Patient Advocacy & Protection Act

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Stein
Analysis of: PCS to First Edition
S697-CSSQ-48

Date: June 8, 2011
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *The Proposed Committee Substitute for SB 697 prohibits retaliatory employment actions against nurses and provides that the process for filing the complaint, complaint investigation, and conciliation will be in accordance with the provisions outlined in the current law on retaliatory employment discrimination.*

BILL ANALYSIS: Section 1 of the Proposed Committee Substitute for SB 697 amends Article 9A Nursing Practice Act, of Chapter 90 Medicine, Allied Occupations, by adding a new section to prohibit retaliatory employment actions. G.S. 90-171.47A prohibits an employer providing healthcare services from discrimination or retaliatory action against a nurse who in good faith and with a reasonable factual or legal basis does the following:

- Discloses or threatens to disclose to a regulatory board an activity, policy, or practice of the employer that is in violation of a law or rule, or that fails to meet appropriate standards of medical care.
- Provides information to or testifies before a regulatory agency conducting an investigation, hearing, or inquiry into any such violation or failure to meet the appropriate standard of medical care.
- Advises another of his or her rights under the section.

Subsection (b) of the new section provides that in order for the nurse to be eligible for the protections, all of the following must apply:

- The nurse reasonably believes that the employer's activity poses a significant danger to the health or welfare of patients.
- The nurse must have reported in writing the activity, policy, or practice to a supervisor, administrator, or other appropriate person identified in the employer's internal compliance plan; and the employer, after reasonable opportunity, has not corrected the activity, policy, or practice.

Subsection (c) provides that a nurse allegedly aggrieved by a violation of the section may file a written complaint with the Commissioner of Labor alleging the violation, subject to the provisions of Article 21 of Chapter 95 which pertains to Retaliatory Employment Discrimination.

Section 2 of the bill amends G.S. 95-242, the Retaliatory Employment Discrimination Article in Chapter 95 (Labor Relations), to add reference to provision contained in Section 1 of the bill. This change allows an employee allegedly aggrieved by a violation of G.S. 90-171.47A to file a written complaint with the Commissioner of Labor. The current law in G.S. 95-242 outlines the process for filing the complaint, complaint investigation, and conciliation.

EFFECTIVE DATE: Senate Bill 697 would become effective when it becomes law and applies to reports made on or after that date.

S697-SMSH-99(CSSQ-48) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 697
PROPOSED COMMITTEE SUBSTITUTE S697-PCS15181-SQ-48

Short Title: Patient Advocacy & Protection Act:

(Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED
AN ACT PROHIBITING RETALIATION AGAINST ANY NURSE WHO MAKES A GOOD
FAITH REPORT CONCERNING PATIENT MEDICAL CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 9A of Chapter 90 of the General Statutes is amended by
adding a new section to read:

"§ 90-171.47A. Retaliatory employment actions prohibited.

(a) An employer providing health care services may not discriminate or take retaliatory
action against a nurse licensed or registered under this Article because the nurse in good faith,
with a reasonable factual or legal basis, does any of the following:

(1) Discloses or threatens to disclose to a supervisor, an internal compliance
reporting system, or a regulatory board an activity, policy, or practice of the
employer that is in violation of a law or rule or that fails to meet appropriate
standards of medical care.

(2) Provides information to, or testifies before, a regulatory agency conducting
an investigation, hearing, or inquiry into a violation or a failure to meet the
appropriate standard of medical care.

(3) Advises another of his or her rights under this section.

(b) To establish eligibility for the protections provided by this section, all of the
following shall apply:

(1) The nurse must reasonably believe that the employer's activity poses a
significant danger to the health or welfare of patients.

(2) The nurse must have reported in writing the activity, policy, or practice to a
supervisor, administrator, or other appropriate person identified in the
employer's internal compliance plan, and the employer, after reasonable
opportunity, has not corrected the activity, policy, or practice.

(c) A nurse allegedly aggrieved by a violation of this section may file a written
complaint with the Commissioner of Labor alleging the violation, subject to the provisions of
Article 21 of Chapter 95 of the General Statutes. In any action brought under this subsection, it
is a defense that the employer's personnel action was based on grounds other than the nurse's
exercise of any rights protected under this section."

SECTION 2. G.S. 95-242(a) reads as rewritten:

"§ 95-242. Complaint; investigation; conciliation.



* S 6 9 7 - P C S 1 5 1 8 1 - S Q - 4 8 *

1 (a) An employee allegedly aggrieved by a violation of G.S. 95-241 or G.S. 90-171.47A
2 may file a written complaint with the Commissioner of Labor alleging the violation. The
3 complaint shall be filed within 180 days of the alleged violation. Within 20 days following
4 receipt of the complaint, the Commissioner shall forward a copy of the complaint to the person
5 alleged to have committed the violation and shall initiate an investigation. If the Commissioner
6 determines after the investigation that there is not reasonable cause to believe that the allegation
7 is true, the Commissioner shall dismiss the complaint, promptly notify the employee and the
8 respondent, and issue a right-to-sue letter to the employee that will enable the employee to
9 bring a civil action pursuant to G.S. 95-243. If the Commissioner determines after investigation
10 that there is reasonable cause to believe that the allegation is true, the Commissioner shall
11 attempt to eliminate the alleged violation by informal methods which may consist of
12 conference, conciliation, and persuasion. The Commissioner shall make a determination as
13 soon as possible and, in any event, not later than 90 days after the filing of the complaint."

14 **SECTION 3.** This act is effective when it becomes law and applies to reports made
15 on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 697

Short Title: Patient Advocacy & Protection Act.

(Public)

Sponsors: Senator Stein.

Referred to: Rules and Operations of the Senate.

April 20, 2011

1 A BILL TO BE ENTITLED
2 AN ACT PROHIBITING RETALIATION AGAINST ANY NURSE WHO MAKES A GOOD
3 FAITH REPORT CONCERNING PATIENT MEDICAL CARE OR WHO ENGAGES IN
4 PATIENT ADVOCACY.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. Article 21 of Chapter 95 of the General Statutes is amended by
7 adding a new section to read:

8 "**§ 95-241.1. Retaliation against nurses prohibited.**

9 (a) The following definitions apply in this section:

10 (1) Good faith report. – A report made when the nurse believed in good faith
11 that the report was required or authorized by Article 9A of Chapter 90 of the
12 General Statutes and there was a reasonable factual or legal basis for that
13 belief.

14 (2) Hospital. – A hospital as defined by G.S. 131E-76(3).

15 (3) Nurse. – A registered nurse or licensed practical nurse licensed pursuant to
16 Article 9A of Chapter 90 of the General Statutes, the Nursing Practice Act.

17 (4) Patient advocacy. – Whenever a nurse acting in good faith promotes,
18 advocates for, or attempts to protect the health, safety, and rights of a
19 patient.

20 (5) Peer review. – The evaluation of (i) nursing services, (ii) the qualifications
21 of a nurse, (iii) the quality of patient care rendered by a nurse, and (iv) the
22 merits of a complaint concerning a nurse or nursing care. The term includes
23 a determination or recommendation regarding a complaint.

24 (b) No person or hospital may suspend, terminate, or otherwise discipline, discriminate
25 against, or retaliate against a nurse who makes a good faith report concerning patient medical
26 care or who engages in patient advocacy.

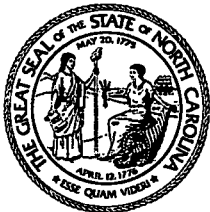
27 (c) No person or hospital may suspend, terminate, or otherwise discipline, discriminate
28 against, or retaliate against a person who advises a nurse of the nurse's rights under this section.

29 (d) A nurse who makes a good faith report concerning patient medical care or who
30 engages in patient advocacy, or any person who advises a nurse of that nurse's rights to make a
31 good faith report, is immune from civil and criminal liability that, in the absence of immunity,
32 might result from making the report or giving the advice.

33 (e) Any person may file a counterclaim in a pending action or prove a cause of action in
34 a subsequent lawsuit to recover defense costs, including reasonable attorneys' fees, and actual
35 and punitive damages, if the person is named as a defendant in a civil action or subjected to
36 other retaliatory action as a result of:

37 (1) Filing a good faith report.





SENATE BILL 508: Clarify Vaccine Exemptions/Emerg. Mgmt Act

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Kinnaird
Analysis of: First Edition

Date: June 8, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 508 would expand medical and religious exemptions to required immunizations under Chapter 130A and Chapter 166A.*

CURRENT LAW: Under G.S. 130A-152, North Carolina requires every child in the State to be immunized against diphtheria, tetanus, whooping cough, poliomyelitis, red measles (rubeola) and rubella. The Commission for Public Health (Commission) and the Department of Health and Human Services (Department) have created rules for procedural implementation of these immunizations, including possible contraindications to receiving the immunizations. This requirement is monitored by entry requirements at child care facilities, schools, and universities.

G.S. 130A-156 grants a medical exemption to the immunizations required under 130A-152 for any individual who possesses a contraindication adopted by the Commission or who has been granted an exemption by the State Health Director.

G.S. 130A-157 grants a religious exemption to the immunizations required under 130A-152 if the religious beliefs of an adult or the parent, guardian or person in loco parentis of a child are contrary to the immunization requirements.

BILL ANALYSIS: Senate Bill 508 would amend G.S. 130A-156 and G.S. 130A-157 by expanding the existing medical and religious exemptions to any immunizations required under Chapter 130A: Social Services and any immunizations required under Chapter 166A: North Carolina Emergency Management Act. The North Carolina Emergency Management Act sets forth the authority of the Governor, State agencies, and local governments in the prevention of, preparation for, response to and recovery from disaster or hostile military or paramilitary action.

EFFECTIVE DATE: This act becomes effective October 1, 2011.

S508-SMTK-46(e1) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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1

SENATE BILL 508

Short Title: Clarify Vaccine Exemptions/Emerg. Mgmt Act. (Public)

Sponsors: Senator Kinnaird.

Referred to: Health Care.

April 5, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO CLARIFY THE APPLICABILITY OF MEDICAL AND RELIGIOUS
3 VACCINE EXEMPTIONS TO THE NORTH CAROLINA EMERGENCY
4 MANAGEMENT ACT.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. G.S. 130A-156 reads as rewritten:

7 "§ 130A-156. Medical exemption.

8 The Commission for Public Health shall adopt by rule medical contraindications to
9 immunizations required by ~~G.S. 130A-152~~ this Chapter or Chapter 166A of the General
10 Statutes. If a physician licensed to practice medicine in this State certifies that a required
11 immunization is or may be detrimental to a person's health due to the presence of one of the
12 contraindications adopted by the Commission, the person is not required to receive the
13 specified immunization as long as the contraindication persists. The State Health Director may,
14 upon request by a physician licensed to practice medicine in this State, grant a medical
15 exemption to a required immunization for a contraindication not on the list adopted by the
16 Commission."

17 SECTION 2. G.S. 130A-157 reads as rewritten:

18 "§ 130A-157. Religious exemption.

19 If the bona fide religious beliefs of an adult or the parent, guardian or person in loco
20 parentis of a child are contrary to the immunization requirements contained in this
21 ~~Chapter~~ Chapter or Chapter 166A of the General Statutes, the adult or the child shall be exempt
22 from the requirements. Upon submission of a written statement of the bona fide religious
23 beliefs and opposition to the immunization requirements, the person may attend the college,
24 university, school or facility without presenting a certificate of immunization."

25 SECTION 3. This act becomes effective October 1, 2011.





HOUSE BILL 397: DHHS Penalties and Remedies Revision.-AB

2011-2012 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	Date:	June 8, 2011
Introduced by:	Rep. Lewis	Prepared by:	Shawn Parker
Analysis of:	Second Edition		Committee Counsel

SUMMARY: *HB 397 amends the penalty provisions for nursing home facilities, adult care facilities, and facilities providing services to the mentally ill, developmentally disabled, and substance abusers. The penalty provisions for each type of facility are substantially similar.*

CURRENT LAW: G.S. 122C-24.1 provides for the imposition of administrative penalties on licensed facilities providing services to the mentally ill, developmentally disabled, and substance abusers.

G.S. 131D-34 provides for the imposition of administrative penalties on licensed adult care facilities that are in violation of residents' rights set forth in G.S. 131D-21, or other State or federal law or regulation.

G.S. 131E-129 provides for the imposition of administrative penalties for nursing homes which are in violation of residents' rights as set forth in G.S. 131E-117 or applicable State and federal laws and regulations.

BILL ANALYSIS: House Bill 357 amends the provisions for the imposition of administrative penalties on nursing care facilities, G.S. 131E-129, adult care facilities, G.S. 131D-34, and facilities providing services to the mentally ill, developmentally disabled and substance abusers, G.S. 122C-24.1. Violations at these facilities will be classified and processed as follows:

1. **Type A1 violations.** Violations by a facility of State or federal laws or regulations that result in death or serious physical harm, abuse, neglect or exploitation.

The person making the finding of violation must:

- Orally and immediately inform the facility of the Type A1 violation and the specific findings.
- Require a written plan of protection for the abatement of the violation in order to protect clients from further risk of harm.
- Within 15 working days of the investigation, send a report of the findings to the facility.
- Require a plan of correction from the facility describing the steps the facility will take to achieve and maintain compliance.

For a Type A1 violation the Department of Health and Human Services (DHHS) must impose a civil penalty. For facilities serving 6 or fewer persons, the fines shall be not less than \$500 nor more than \$10,000. Facilities serving 7 or more may be assessed not less than \$1,000 nor more than \$20,000 *(These penalty amounts are in the current statute.)*

Failure to correct a Type A1 shall result in the assessment of a penalty of \$1000 for each day the violation continues beyond the time specified for correction.

2. **Type A2 violations.** Violations by a facility of the laws and regulations that results in a substantial risk of death, serious physical harm, abuse, neglect, or exploitation.

The person making the finding of Type A2 violation must follow the same procedure as for a Type A1 violation.

House Bill 397

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DHHS may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Failure to correct a Type A2 violation shall result the assessment of a civil penalty of up to \$1,000 for each day the deficiency continues beyond the time specified for correction.

3. Past Corrected Type A1 or A2 Violation. A violation that either (1) was not previously identified by DHHS or (2) was discovered by the facility and self reported, but in either case the violation was corrected. In determining whether a penalty should be assessed, DHHS shall consider:

- Preventative measures in place prior to the violation.
- Whether the violation was abated immediately.
- Whether corrective measures were implemented.
- Whether the facility's system to ensure compliance is maintained and implemented.
- Whether the regulatory area remains in compliance.

4. Type B Violation. A Type B violation is one that is detrimental to the health, safety, or wellbeing of a resident, but which does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur.

The person making the finding of a violation shall follow the same procedure as for a Type A1 or A2 violation.

5. Repeat Violations. DHHS shall impose a civil penalty 3x the amount earlier assessed when a facility under the same management or ownership has received a citation for violating the same specific provisions of the law or regulations during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred. *(The trebling of the penalty is in the current statute. Current law also provides for the penalty to be assessed if a facility has received a citation for the same specific violation).*

6. Factors to be considered in determining amount of initial penalty.

- Substantial risk that serious physical harm, abuse, neglect, or exploitation will occur.
- Serious physical harm, abuse, neglect, or exploitation, without substantial risk of death did occur.
- Serious physical harm, abuse, neglect, or exploitation, with substantial risk of death did occur.
- A client died.
- A client died and there is substantial risk to others of serious physical harm, abuse, neglect, or exploitation.
- A client died, and there is substantial risk for further client death.
- The reasonable diligence of the facility to comply with State and federal law and regulations.
- Efforts to correct violations.
- Number and type of violations within the previous 36 months.
- Number of clients put at risk by the violation.

House Bill 397

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7. Staff Training in Lieu of Penalty. In lieu of assessing all or part of a penalty, the Secretary may order a facility to provide staff training that is specific to the violation, approved by DHHS and taught by someone approved by DHHS.

8. Miscellaneous. In addition to the above provisions, the bill provides that DHHS shall impose a \$50/day penalty for failure to allow an authorized DHHS representative to inspect the premises and records of the facility.

For facilities serving the mentally ill, developmentally disabled, or substance abusers, any penalty imposed shall commence on the date of the letter of notification of the penalty amount. For adult care facilities and nursing homes, any penalty imposed shall commence the date the violation was identified.

In addition to the above:

Section 2 amends G.S. 131D-34(c1), which provides for the findings in support of an administrative penalty to be made available to all affected parties, to add the family member who serves as a responsible party or those who have legal authority on behalf of the affected resident, to the list of those who are entitled to receive the written record.

Section 2 also amends G.S. 131D-34(d1) to provide that the penalty for the provision of false information or omission of information on a licensure application requesting information on owners, administrators, principals, or affiliates of the facility is the same as for a Class A1 violation.

Section 3 amends G.S. 131E-129(c1), which provides for the findings in support of an administrative penalty to be made available to all affected parties, to add the family member who serves as a responsible party or those who have legal authority on behalf of the affected resident, to the list of those who are entitled to receive the written record.

Section 3 also amends G.S. 131E-129(e) to provide that a petition for a contested case shall be filed within 30 days after DHHS mails a notice of penalty to a licensee.

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

Barbara Riley, counsel to House Judiciary A, substantially contributed to this summary.

H397-SMSQ-41(e2) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 397
Committee Substitute Favorable 4/20/11

Short Title: DHHS Penalties and Remedies Revision.-AB

(Public)

Sponsors:

Referred to:

March 17, 2011

A BILL TO BE ENTITLED
AN ACT REVISING PENALTIES AND REMEDIES CONCERNING HEALTH
FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-24.1 reads as rewritten:

"§ 122C-24.1. Penalties; remedies.

(a) ~~Violations Classified.~~ Violation Classification and Penalties. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified and penalties assessed according to the nature of the violation as follows:

(1) "Type A-~~A1~~ Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. ~~harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:~~

a. Orally and immediately inform the ~~administrator of the facility of the Type A1 Violation and the specific findings and what must be done to correct them, and set a date by which the violation must be corrected; findings.~~

a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect clients from further risk or additional harm.

b. Within ~~40~~ 15 working days of the investigation, ~~confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and send a report of the findings to the facility.~~

c. ~~Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department. Require a plan of correction to be submitted to the Department, based on a written report of the findings, that describes steps the facility will take to achieve and maintain compliance.~~



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The Department shall impose a civil penalty in an amount not less than five hundred dollars (\$500.00) nor more than ten thousand dollars (\$10,000) for each Type A-A1 Violation in facilities or programs that serve six or fewer persons. The Department shall impose a civil penalty in an amount not less than one thousand dollars (\$1,000) nor more than twenty thousand dollars (\$20,000) for each Type A-A1 Violation in facilities or programs that serve seven or more persons.

Where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars (\$1,000) for each day that the violation continues beyond the time specified for correction. The Department or its authorized representative shall determine whether the violation has been corrected.

(1a) "Type A2 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

- a. Orally and immediately inform the facility of the Type A2 Violation and the specific findings.
- b. Require a written plan of protection regarding how the facility will immediately abate the Type A2 Violation in order to protect clients or residents from further risk or additional harm.
- c. Within 15 working days of the investigation, send a report of the findings to the facility.
- d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The violation or violations shall be corrected within the time specified for correction by the Department or its authorized representative. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Where a facility has failed to correct a Type A2 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars (\$1,000) for each day that the deficiency continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

(1b) "Past Corrected Type A1 or Type A2 Violation" means either (i) the violation was not previously identified by the Department or its authorized representative or (ii) the violation was discovered by the facility as was self-reported, but in either case the violation has been corrected. In determining whether a penalty should be assessed under this section, the Department shall consider the following factors:

- a. Preventative measures in place prior to the violation.
- b. Whether the violation or violations were abated immediately.
- c. Whether the facility implemented corrective measures to achieve and maintain compliance.
- d. Whether the facility's system to ensure compliance is maintained and continues to be implemented.

- 1 e. Whether the regulatory area remains in compliance.
- 2 (2) "Type B Violation" means a violation by a facility of the regulations,
3 standards, and requirements set forth in Article 2 or 3 of this Chapter or
4 applicable State or federal laws and regulations governing the licensure or
5 certification of a facility which ~~present a direct relationship is detrimental~~ to
6 the health, safety, or welfare of any client or patient, but which does not
7 result in substantial risk that death or serious physical ~~harm-harm, abuse,~~
8 ~~neglect, or exploitation~~ will occur. ~~The Department shall require a plan of~~
9 ~~correction for each Type B Violation and may require the facility to establish~~
10 ~~a specific plan of correction within a specific time period to address the~~
11 ~~violation. The person making the findings shall do the following:~~
- 12 a. Orally and immediately inform the facility of the Type B Violation
13 and the specific findings.
- 14 b. Require a written plan of protection regarding how the facility will
15 immediately abate the Type B Violation in order to protect clients or
16 residents from further risk or additional harm.
- 17 c. Within 15 working days of the investigation, send a report of the
18 findings to the facility.
- 19 d. Require a plan of correction to be submitted to the Department, based
20 on the written report of the findings, that describes steps the facility
21 will take to achieve and maintain compliance.
- 22 (b) ~~Penalties for Failure to Correct Violations Within Time Specified.—~~
- 23 (1) ~~Where a facility has failed to correct a Type A Violation, the Department~~
24 ~~shall assess the facility a civil penalty in the amount of up to one thousand~~
25 ~~dollars (\$1,000) for each day that the deficiency continues beyond the time~~
26 ~~specified in the plan of correction approved by the Department or its~~
27 ~~authorized representative. The Department or its authorized representative~~
28 ~~shall ensure that the violation has been corrected.~~
- 29 (2) Where a facility has failed to correct a Type B Violation within the time
30 specified for correction by the Department or its authorized representative,
31 the Department shall assess the facility a civil penalty in the amount of up to
32 four hundred dollars (\$400.00) for each day that the ~~deficiency-violation~~
33 continues beyond the date specified for correction without just reason for the
34 failure. The Department or its authorized representative shall ensure that the
35 violation has been corrected.
- 36 (3) Repeat Violations. — The Department shall impose a civil penalty which is
37 treble the amount assessed under subdivision (1) of this subsection (a) of this
38 section when a facility under the same management, ownership, or control
39 management or ownership has received a citation during the previous 12
40 months for which the appeal rights are exhausted and penalty payment is
41 expected or has occurred, and has received a citation and paid a penalty for
42 the current violation is for violating the same specific provision of a statute
43 or regulation for which it received a citation-violation during the previous 12
44 months.
- 45 (c) Factors to Be Considered in Determining Amount of Initial Penalty. — In
46 determining the amount of the initial penalty to be imposed under this section, the Department
47 shall consider the following factors:
- 48 (1) There is substantial risk that serious physical harm, abuse, neglect, or
49 exploitation will occur, and this has not been corrected within the time
50 specified by the Department or its authorized representative; The gravity of
51 ~~the violation, including the fact that death or serious physical harm to a~~

client or patient has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) Serious physical harm, abuse, neglect, or exploitation, without substantial risk for client death, did occur;~~The gravity of the violation, including the probability that death or serious physical harm to a client or patient will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;~~

(3) Serious physical harm, abuse, neglect, or exploitation, with substantial risk for client death, did occur;~~The gravity of the violation, including the probability that death or serious physical harm to a client or patient may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;~~

(3a) A client died;

(3b) A client died and there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation;

(3c) A client died and there is substantial risk for further client death;

(4) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and other applicable State and federal laws and regulations;

(5) Efforts by the licensee to correct violations;

(6) The number and type of previous violations committed by the licensee within the past 36 months; and

(7) ~~The amount of assessment necessary to ensure immediate and continued compliance; and~~

(8) The number of clients or patients put at risk by the violation.

(d) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The licensee involved;

(2) The clients or patients affected; and

(3) The family members or guardians of the clients or patients affected.

(e) The Department shall impose a civil penalty of fifty dollars (\$50.00) per day on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(f) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(g) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began, date of the letter of notification of the penalty amount.

(h) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

- (2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.
- (i) In lieu of assessing ~~an all or some of the~~ administrative penalty, the Secretary may order a facility to provide staff training ~~if; if the training is:~~
- (1) Specific to the violation;
 - (2) Approved by the Department of Health and Human Services; and
 - (3) Taught by someone approved by the Department.
- ~~(1) The penalty would be for the facility's only violation within a 12 month period preceding the current violation and while the facility is under the same management; and~~
- (2) ~~The training is:~~
- a. ~~Specific to the violation;~~
 - b. ~~Approved by the Department of Health and Human Services; and~~
 - c. ~~Taught by someone approved by the Department and other than the provider.~~
- (j) The clear proceeds of civil penalties provided for in this section shall be remitted to the State Treasurer for deposit in accordance with State law.
- (k) In considering renewal of a license, the Department shall not renew a license if outstanding fines and penalties imposed by the Department against the facility or program have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration for nonrenewal under this subsection."

SECTION 2. G.S. 131D-34 reads as rewritten:

"§ 131D-34. Penalties; remedies.

(a) ~~Violations Classified. Violation Classification and Penalties.~~ – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility which is found to be in violation of requirements of G.S. 131D-21 or applicable State and federal laws and regulations. Citations issued for violations shall be classified and penalties assessed according to the nature of the violation as follows:

- (1) "Type A-~~A1~~ Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation, ~~or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:~~
- a. Orally and immediately inform the ~~administrator of the facility of the Type A1 Violation and the specific findings findings and what must be done to correct them, and set a date by which the violation must be corrected;~~
 - a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect residents from further risk or additional harm.
 - b. ~~Within 10-15 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and send a report of the findings to the facility.~~
 - c. ~~Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department. Require a~~

1 plan of correction to be submitted to the Department, based on the
2 written report of the findings, that describes steps the facility will
3 take to achieve and maintain compliance.

4 The Department shall impose a civil penalty in an amount not less than five
5 hundred dollars (\$500.00) nor more than ten thousand dollars (\$10,000) for
6 each Type A-A1 Violation in ~~homes-facilities~~ licensed for six or fewer beds.

7 The Department shall impose a civil penalty in an amount not less than one
8 thousand dollars (\$1,000) nor more than twenty thousand dollars (\$20,000)
9 for each Type A-A1 Violation in facilities licensed for seven or more beds.

10 Where a facility has failed to correct a Type A1 Violation, the Department
11 shall assess the facility a civil penalty in the amount of up to one thousand
12 dollars (\$1,000) for each day that the violation continues beyond the time
13 specified for correction by the Department or its authorized representative.

14 The Department or its authorized representative shall determine whether the
15 violation has been corrected.

16 (1a) "Type A2 Violation" means a violation by a facility of the regulations,
17 standards, and requirements set forth in G.S. 131D-21 or applicable State or
18 federal laws and regulations governing the licensure or certification of a
19 facility which results in substantial risk that death or serious physical harm,
20 abuse, neglect, or exploitation will occur. The person making the findings
21 shall do the following:

22 a. Orally and immediately inform the facility of the Type A2 Violation
23 and the specific findings.

24 b. Require a written plan of protection regarding how the facility will
25 immediately abate the Type A2 Violation in order to protect clients
26 or residents from further risk or additional harm.

27 c. Within 15 working days of the investigation, send a report of the
28 findings to the facility.

29 d. Require a plan of correction to be submitted to the Department, based
30 on the written report of the findings, that describes steps the facility
31 will take to achieve and maintain compliance.

32 The violation or violations shall be corrected within the time specified for
33 correction by the Department or its authorized representative. The
34 Department may or may not assess a penalty taking into consideration the
35 compliance history, preventative measures, and response to previous
36 violations by the facility. Where a facility has failed to correct a Type A2
37 Violation, the Department shall assess the facility a civil penalty in the
38 amount of up to one thousand dollars (\$1,000) for each day that the
39 deficiency continues beyond the time specified for correction by the
40 Department or its authorized representative. The Department or its
41 authorized representative shall determine whether the violation has been
42 corrected.

43 (1b) "Past Corrected Type A1 or Type A2 Violation" means either (i)
44 the violation was not previously identified by the Department or its
45 authorized representative or (ii) the violation was discovered by the facility
46 and was self-reported, but in either case the violation has been corrected. In
47 determining whether a penalty should be assessed under this section, the
48 Department shall consider the following factors:

49 a. Preventive systems in place prior to the violation.

50 b. Whether the violation or violations were abated immediately.

- 1 c. Whether the facility implemented corrective measures to achieve
2 maintain compliance.
- 3 d. Whether the facility's system to ensure compliance is maintained and
4 continues to be implemented.
- 5 e. Whether the regulatory area remains in compliance.
- 6 (2) "Type B Violation" means a violation by a facility of the regulations,
7 standards and requirements set forth in G.S. 131D-21 or applicable State or
8 federal laws and regulations governing the licensure or certification of a
9 facility which ~~is detrimental present a direct relationship to the health,~~
10 safety, or welfare of any resident, but which does not result in substantial
11 risk that death or serious physical ~~harm-harm, abuse, neglect, or exploitation~~
12 will occur. ~~The Department shall require a plan of correction for each Type~~
13 ~~B Violation and may require the facility to establish a specific plan of~~
14 ~~correction within a reasonable time period to address the violation. The~~
15 ~~required plan cannot exceed requirements imposed by existing rule or~~
16 ~~law. The person making the findings shall do the following:~~
- 17 a. Orally and immediately inform the facility of the Type B Violation
18 and the specific findings.
- 19 b. Require a written plan of protection regarding how the facility will
20 immediately abate the Type B Violation in order to protect residents
21 from further risk or additional harm.
- 22 c. Within 15 working days of the investigation, send a report of the
23 findings to the facility.
- 24 d. Require a plan of correction to be submitted to the Department, based
25 on the written report of the findings, that describes steps the facility
26 will take to achieve and maintain compliance.
- 27 (b) ~~Penalties for failure to correct violations within time specified.~~
- 28 (1) ~~Where a facility has failed to correct a Type A Violation, the Department~~
29 ~~shall assess the facility a civil penalty in the amount of up to one thousand~~
30 ~~dollars (\$1,000) for each day that the deficiency continues beyond the time~~
31 ~~specified in the plan of correction approved by the Department or its~~
32 ~~authorized representative. The Department or its authorized representative~~
33 ~~shall ensure that the violation has been corrected.~~
- 34 (2) Where a facility has failed to correct a Type B Violation within the time
35 specified for correction by the Department or its authorized representative,
36 the Department shall assess the facility a civil penalty in the amount of up to
37 four hundred dollars (\$400.00) for each day that the ~~deficiency-violation~~
38 continues beyond the date specified for correction without just reason for
39 such failure. The Department or its authorized representative shall ensure
40 that the violation has been corrected.
- 41 (3) Repeat Violations. – The Department shall impose a civil penalty which is
42 treble the amount assessed under subdivision (1) of subsection (a) of this
43 section when a facility under the same management, ownership, or control
44 has received a citation management or ownership has received a citation
45 during the previous 12 months for which the appeal rights are exhausted and
46 penalty payment is expected or has occurred, and the current violation is and
47 paid a penalty for violating the same specific provision of a statute or
48 regulation for which it received a citation-violation during the previous 12
49 months. The counting of the 12-month period shall be tolled during any time
50 when the facility is being operated by a court-appointed temporary manager
51 pursuant to Article 4 of this Chapter.

(c) ~~Factors to be considered in determining amount of initial penalty. Factors to Be~~
Considered in Determining Amount of Initial Penalty. – In determining the amount of the
initial penalty to be imposed under this section, the Department shall consider the following
factors:

(1) ~~The gravity of the violation, including the fact that death or serious physical~~
~~harm to a resident has resulted; the severity of the actual or potential harm,~~
~~and the extent to which the provisions of the applicable statutes or~~
~~regulations were violated; There is substantial risk that serious physical harm,~~
~~abuse, neglect, or exploitation will occur;~~

(1a) ~~The gravity of the violation, including the probability that death or serious~~
~~physical harm to a resident will result; the severity of the potential harm, and~~
~~the extent to which the provisions of the applicable statutes or regulations~~
~~were violated; Serious physical harm, abuse, neglect, or exploitation,~~
~~without substantial risk for resident death, did occur;~~

(1b) ~~The gravity of the violation, including the probability that death or serious~~
~~physical harm to a resident may result; the severity of the potential harm,~~
~~and the extent to which the provisions of the applicable statutes or~~
~~regulations were violated; Serious physical harm, abuse, neglect, or~~
~~exploitation, with substantial risk for resident death, did occur;~~

(1c) A resident died;

(1d) A resident died and there is substantial risk to others for serious physical
harm, abuse, neglect, or exploitation;

(1e) A resident died and there is substantial risk for further resident death;

(2) The reasonable diligence exercised by the licensee to comply with
G.S. 131E-256 and G.S. 131E-265 G.S. 131D-21 and other applicable State
and federal laws and regulations;

(2a) Efforts by the licensee to correct violations;

(3) The number and type of previous violations committed by the licensee
within the past 36 months; and

(4) ~~The amount of assessment necessary to insure immediate and continued~~
~~compliance; and~~

~~(5)~~ (4) The number of patients-residents put at risk by the violation.

(c1) The facts found to support the factors in subsection (c) of this section shall be the
basis in determining the amount of the penalty. The ~~Secretary-Department~~ shall document the
findings in written record and shall make the written record available to all affected parties
including:

(1) The penalty review committee;

(2) The local department of social services who is responsible for oversight of
the facility involved;

(3) The licensee involved;

(4) The residents affected; and

(5) ~~The family members or guardians of the residents affected. The family~~
member who serves as a responsible party or those who have legal authority
on behalf of the affected resident.

(c2) Local county departments of social services and Division of Health Service
Regulation personnel shall submit proposed penalty recommendations to the Department within
45 days of the citation of a violation.

(d) The Department shall impose a civil penalty of fifty dollars (\$50.00) per day on any
facility which refuses to allow an authorized representative of the Department to inspect the
premises and records of the facility.

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A-A1 Violation.

(e) Any facility wishing to contest a penalty 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 a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(f) ~~Notwithstanding the notice requirements of G.S. 131D-26(b), any~~ Any penalty imposed by the Department of Health and Human Services under this section shall commence on the day ~~the violation began.~~ date the violation was identified.

(g) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(g1) In lieu of assessing ~~an all or some of the~~ administrative penalty, the Secretary may order a facility to provide staff training ~~if:~~ if the training is:

(1) Specific to the violation;

(2) Approved by the Department of Health and Human Services; and

(3) Taught by someone approved by the Department.

(1) ~~The cost of training does not exceed one thousand dollars (\$1,000);~~

(2) ~~The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and~~

(3) ~~The training is:~~

a. ~~Specific to the violation;~~

b. ~~Approved by the Department of Health and Human Services; and~~

c. ~~Taught by someone approved by the Department and other than the provider.~~

(h) The Secretary shall establish a penalty review committee within the Department, which shall meet as often as needed, but no less frequently than once each quarter of the year, to review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129 as follows:

(1) The Secretary shall administer the work of the Committee and provide public notice of its meetings via Web site, and provide direct notice to the following parties involved in the penalties the Committee will be reviewing:

a. The licensed provider, who upon receipt of the notice, shall post the notice of the scheduled Penalty Review Committee meeting in a conspicuous place available to residents, family members, and the public;

- b. The local department of social services that is responsible for oversight of the facility involved;
- c. The residents affected; and
- d. Those individuals lawfully designated by the affected resident to make health care decisions for the resident.
- (2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:
- a. A licensed pharmacist;
- b. A registered nurse experienced in long term care;
- c. A representative of a nursing home;
- d. A representative of an adult care home; and
- e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.
- (3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be employed by or own any interest in a nursing home or adult care home.
- (4) Repealed by Session Laws 2005-276, s. 10.40A(l), effective July 1, 2005.
- (4a) Repealed by Session Laws 2007-544, s. 1, effective October 1, 2007.
- (4b) Prior to serving on the Committee, each member shall complete a training program provided by the Department of Health and Human Services that covers standards of care and applicable State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.
- (5) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.
- (6) The Committee shall be cochaired by:
- a. One member of the Department outside of the Division of Health Service Regulation; and
- b. One member who is not affiliated with the Department.
- (i) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund State Treasurer for deposit in accordance with G.S. 115C-457.2 State law."
- SECTION 3. G.S. 131E-129 reads as rewritten:**
- "§ 131E-129. ~~Penalties.~~Penalties; remedies.**
- (a) ~~Violations classified.~~Violation Classification and Penalties. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Part Article on any ~~facility's licensee~~ facility which is found to be in violation of the requirements of G.S. 131E-117 or applicable State and federal laws and regulations. Citations ~~issued for violations~~ shall be classified and penalties assessed according to the nature of the violation as follows:

(1) ~~"Type A-A1 Violation" means a violation by a facility's licensee-facility of the regulations, standards, regulations and requirements set forth in G.S. 131E-117, or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. harm. The person making the findings shall do the following:~~

- a. ~~Orally and immediately inform the administrator of the facility of the Type A1 Violation and the specific findings and what must be done to correct them and set a date by which the violation must be corrected; findings.~~
- b. ~~Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and~~
- c. ~~Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.~~
- d. Require a written, credible allegation regarding how the facility will immediately remove the Type A1 Violation in order to protect residents from further risk or additional harm.
- e. Within 15 working days of the investigation, send a report of the findings to the facility.
- f. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance by the date specified by the Department.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ~~(\$500.00) one thousand dollars (\$1,000) nor more than ten thousand dollars (\$10,000) twenty thousand dollars (\$20,000)~~ for each Type A-A1 Violation. Where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars (\$1,000) for each day that the violation continues beyond the date specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

(1a) "Type A2 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131E-117 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in substantial risk that death or serious physical harm will occur. The person making the findings shall do the following:

- a. Orally and immediately inform the facility of the Type A2 Violation and the specific findings.
- b. Require a credible allegation regarding how the facility will immediately remove the Type A2 Violation in order to protect residents from further risk or additional harm.
- c. Within 10 working days of the investigation, send a report of the findings to the facility.
- d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility

will take to achieve and maintain compliance by the date specified by the Department.

The violation or violations shall be corrected within the time specified for correction by the Department or its authorized representative. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Where a facility has failed to correct a Type A2 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars (\$1,000) for each day that the deficiency continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

(1b) "Past Corrected Type A1 or Type A2 Violation" means either (i) the violation was not previously identified by the Department or its authorized representative or (ii) the violation was discovered by the facility and was self-reported, but in either case the violation has been corrected. In determining whether a penalty should be assessed under this section, the Department shall consider the following factors:

- a. Preventive systems in place prior to the violation.
- b. Whether the violation or violations were abated immediately. and
- c. Whether the facility implemented corrective measures to achieve and maintain compliance.
- d. Whether the facility's system to ensure compliance is maintained and continues to be implemented.
- e. Whether the regulatory area remains in compliance.

(2) "Type B Violation" means a violation by a facility's licensee of the regulations, standards and requirements set forth in G.S. 131E-117 or applicable State or federal laws and regulations governing the licensure or certification of a facility which ~~presents a direct relationship is detrimental to~~ the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur. The Department ~~shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.~~ The person making the findings shall do the following:

- a. Orally and immediately inform the facility of the Type B Violation and the specific findings.
- b. Require a written plan regarding how the facility will immediately remove the Type B Violation in order to protect residents from further risk or additional harm.
- c. Within 10 working days of the investigation, send a report of the findings to the facility.
- d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance by the date specified by the Department.

Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars (\$400.00) for each day that the violation continues

beyond the date specified for correction without just reason for such failure.
The Department or its authorized representative shall ensure that the violation has been corrected.

(3) Repeat Violations. – The Department shall impose a civil penalty which is treble the amount assessed under subsection (a) of this section when a facility under the same management or ownership has received a citation during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred, and the current violation is for the same specific provision of a statute or regulation for which it received a violation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a court-appointed temporary manager pursuant to law.

(b) Penalties for failure to correct violations within time specified.

(1) Where a facility's licensee has failed to correct a Type A Violation, the Department shall assess the facility's licensee a civil penalty in the amount of up to five hundred dollars (\$500.00) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility's licensee has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility's licensee a civil penalty in the amount of up to two hundred dollars (\$200.00) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative without just reason for such failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty on a facility's licensee which is treble the amount assessed under subdivision (1) of subsection (a) when a facility under the management, ownership, or control of that same licensee has received a citation and paid a penalty for violating the same specific provision of a statute or regulation for which the facility's licensee has received a citation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a court-appointed temporary manager pursuant to Article 13 of this Chapter.

(c) Factors to be considered in determining amount of initial penalty. In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a resident has resulted; the severity of the actual or potential harm; and the extent to which the provisions of the applicable statutes or regulations were violated;

(1a) The gravity of the violation, including the probability that death or serious physical harm to a resident will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(1b) The gravity of the violation, including the probability that death or serious physical harm to a resident may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

- (2) ~~The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131E-265 and other applicable State and federal laws and regulations;~~
- (2a) ~~Efforts by the licensee to correct violations;~~
- (3) ~~The number and type of previous violations committed by the licensee within the past 36 months;~~
- (4) ~~The amount of assessment necessary to insure immediate and continued compliance; and~~
- (5) ~~The number of patients put at risk by the violation.~~
- (1) There is substantial risk that serious physical harm, abuse, neglect, or exploitation will occur.
- (2) Serious physical harm, abuse, neglect, or exploitation, without substantial risk for resident death, did occur.
- (3) Serious physical harm, abuse, neglect, or exploitation, with substantial risk for resident death, did occur.
- (4) A resident died.
- (5) A resident died and there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation.
- (6) A resident died and there is substantial risk for further resident death.
- (7) Reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131E-265 did occur.
- (8) Efforts by the licensee to correct violations.
- (9) The number and type of previous violations committed by the licensee within the past 36 months.
- (10) The number of residents put at risk by the violations.
- (c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Secretary shall document the findings in written record and shall make the written record available to all affected parties including:
- (1) The penalty review committee;
- (2) The local department of social services who is responsible for oversight of the facility involved;
- (3) The licensee involved;
- (4) The residents affected; and
- (5) ~~The family members or guardians of the residents affected.~~ The family member who serves as a responsible party or those who have legal authority on behalf of the affected resident.
- (c2) Local county departments of social services and Division of Health Service Regulation personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation.
- (d) The Department shall impose a civil penalty of fifty dollars (\$50.00) per day on any ~~facility's licensee facility~~ which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.
- (e) Any ~~facility's licensee facility~~ wishing to contest a penalty 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 a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:
- (1) The reasonableness of the amount of any civil penalty assessed, and
- (2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

1 If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to
2 be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

3 (e1) Notwithstanding the notice requirements of G.S. 131E-24, any penalty imposed by
4 the Department of Health and Human Services under this section shall commence on the day
5 the penalty is imposed.

6 (f) The Secretary may bring a civil action in the superior court of the county wherein
7 the violation occurred to recover the amount of the administrative penalty whenever a facility's
8 licensee: facility:

9 (1) Which has not requested an administrative hearing fails to pay the penalty
10 within 60 days after being notified of the penalty; or

11 (2) Which has requested an administrative hearing fails to pay the penalty
12 within 60 days after receipt of a written copy of the decision as provided in
13 G.S. 150B-36.

14 (g) The penalty review committee established pursuant to G.S. 131D-34(h) shall review
15 administrative penalties assessed pursuant to this section.

16 (g1) In lieu of assessing ~~an all or some of the~~ administrative penalty, the Secretary may
17 order a facility to provide staff training ~~if~~ if the training is:

18 (1) ~~The cost of training does not exceed one thousand dollars (\$1,000);~~

19 (2) ~~The penalty would be for the facility's only violation within a 12-month~~
20 ~~period preceding the current violation and while the facility is under the~~
21 ~~same management; and~~

22 (3) ~~The training is:~~

23 ~~a. (1) Specific to the violation;~~

24 ~~b. (2) Approved by the Department of Health and Human Services; and~~

25 ~~c. (3) Taught by someone an individual approved by the Department and other~~
26 ~~than the provider. Department.~~

27 (h) The Department shall not assess an administrative penalty against a facility under
28 this section if a civil monetary penalty has been assessed for the same violation under federal
29 enforcement laws and regulations.

30 (i) The clear proceeds of civil penalties provided for in this section shall be remitted to
31 the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

32 **SECTION 4.** This act is effective when it becomes law.



HOUSE BILL 509: Exclusions From Licensure: Home Services

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Rep. Hurley
Analysis of: First Edition

Date: June 8, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *House Bill 509 would provide that certain homes for the mentally ill, developmentally disabled and substance abusers are not subject to licensure.*

CURRENT LAW: G.S. 122C-23 requires facilities for the mentally ill, developmentally disabled, or substance abusers to be licensed by the Secretary of the Department of Health and Human Services (DHHS). Before a facility can be licensed, the local management entity (LME) must verify that additional beds are needed in the LME's catchment area. A licensed home is subject to an annual DHHS inspection and, in the event of a complaint, unscheduled inspections without notice. Licensed facilities are subject to civil penalties under G.S. 122C-24.1 for failing to comply with applicable State and federal laws and regulations, including mandatory rules that affect the health, safety or welfare of residents.

Currently, G.S. 122C-22 lists eleven categories of persons or facilities that are not required to obtain licensure:

- (1) Physicians and psychologists engaged in private office practice;
- (2) General hospitals licensed under Article 5 of Chapter 131E of the General Statutes, that operate special units for the mentally ill, developmentally disabled, or substance abusers;
- (3) State and federally operated facilities;
- (4) Adult care homes licensed under Chapter 131D of the General Statutes;
- (5) Developmental child care centers licensed under Article 7 of Chapter 110 of the General Statutes;
- (6) Persons subject to licensure under rules of the Social Services Commission;
- (7) Persons subject to rules and regulations of the Division of Vocational Rehabilitation Services;
- (8) Facilities that provide occasional respite care for not more than two individuals at a time; provided that the primary purpose of the facility is other than as defined in G.S. 122C-3(14);
- (9) Twenty-four-hour nonprofit facilities established for the purposes of shelter care and recovery from alcohol or other drug addiction through a 12-step, self-help, peer role modeling, and self-governance approach;
- (10) Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Correction, as described in G.S. 148-19.1; and
- (11) A charitable, nonprofit, faith-based, adult residential treatment facility that does not receive any federal or State funding and is part of an international organization serving at least 50 countries that helps persons ages 18 through 40 overcome life-controlling problems and is a religious organization exempt from federal income tax under section 501(a) of the Internal Revenue Code.

BILL ANALYSIS: Under current law, when services are provided in a home with more than two people, the licensure requirement applies. House Bill 509 would allow up to three adults, at least two of whom are mentally ill, developmentally disabled, or a substance abuser, to receive three or more hours of day services or up to 24 hours of residential services in a home which they either rent or own together. Persons with disabilities could not be required to move into an institutional setting if they changed services or service providers or discontinued services.

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

Jan Paul, counsel to House Health, substantially contributed to this summary.

H509-SMSQ-42(e1) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

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HOUSE BILL 509

Short Title: Exclusions From Licensure: Home Services. (Public)

Sponsors: Representative Hürley (Primary Sponsor).
For a complete list of Sponsors, see Bill Information on the NCGA Web Site.

Referred to: Health and Human Services.

March 30, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO EXCLUDE FROM LICENSURE AS A FACILITY CONSUMERS LIVING IN
3 THEIR OWN HOME AND RECEIVING SERVICES.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. G.S. 122C-22(a) is amended by adding a new subsection to read:

6 "§ 122C-22. Exclusions from licensure; deemed status.

7 (a) The following are excluded from the provisions of this Article and are not required
8 to obtain licensure under this Article:

9 ...
10 (12) A home in which up to three adults, two or more having a disability, co-own
11 or co-rent a home in which the persons with disabilities are receiving three
12 or more hours of day services in the home or up to 24 hours of residential
13 services in the home. The individuals who have disabilities cannot be
14 required to move if the individuals change services, change service
15 providers, or discontinue services."

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



VISITOR REGISTRATION SHEET

Committee on Health Care

6/8/11

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lon Kiler	NCA/TCF
Angie Harris	WM
HT Wilson	NCA/TA
BJ Miller	Cove Health
Allison Waller	Nelson Mullins
Patricia J. Gancey	APPCNC/NCAAP
Lon Hoffmann	LATA
Hiy Ella	NCA/MT
Chuck Stone	SEANC
Deon Sips	Smith Lines

VISITOR REGISTRATION SHEET

Committee on Health Care

6/8/44

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
MICHAEL MOUSE	
Reg M	
Sam Salomuro	ERK
Ang White	NCMS
Diana Hauer	NCATA, NCNA
TINA GORDON	NCNurses
Jennifer Mahon	AGNC
Annaliese Dolph	DRNC
Mary Beth	AARP NC
JESSE GOODMAN	DHHS/DHQR

MINUTES

SENATE HEALTH CARE COMMITTEE

Wednesday, June 14 2011

Room 1124

The Senate Health Care Committee met on Tuesday, June 14, 2011, in Room 1124 of the Legislative Building with Senator Louis Pate presiding. There were 12 members present.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Charles Harper and Donna Blake. He then recognized the Pages helping with the Committee.

The first bill to be discussed was SB 467, "Naturopathic Licensing Act." Senator Hartsell was not available to explain the bill, however, several doctors from UNC spoke regarding it and answered questions. Senator Pate displaced the bill temporarily until Senator Hartsell was available to explain the bill in detail. More questions were asked and answered, and Senator Tucker moved for a Favorable Report with Unfavorable to the Original Bill and referred to Finance. Motion carried.

House Bill 622, "Nursing Homes/Food Services Inspections" was the next bill to be discussed. Representative McCormick explained the bill. Senator Robinson moved for a Favorable Report; motion carried.

House Bill 809 was next on the Agenda and explained by Representative Burr. Senator Bingham entered an amendment; Senator Tucker moved for the amendment to be accepted, give a Favorable Report as Amended with Unfavorable as to Original Bill.

House Bill 677, "Discharge of Adult Care Home Residents" was explained by Representative Lewis. After answering questions posed by the members, Senator Tucker moved for a Favorable Report to the PCS, Unfavorable to the Original Bill. Motion carried.

House Bill 678, "Pilot Release of Inmates to Adult Care Home Residents" was brought before the Committee, and explained by Representative Lewis. Questions were asked by members, afterwards Senator Robinson moved for a Favorable Report. Motion carried.

Senate Health Care Committee
June 14, 2011
Pate 2

Having heard all bills on the Agenda, the meeting was adjourned at 10:00 a.m.

Respectfully submitted,



Senator Louis M. Pate, Jr., Chair



Edna Pearce, Committee Clerk

Edna Pearce (Sen. Pate)

From: Maria Kinnaird (Sen. Bingham)
it: Thursday, June 09, 2011 4:05 PM
--- Sen. Fletcher Hartsell, Jr.; Sen. Tom Apodaca; Rep. Darrell G. McCormick; Rep. George Cleveland; Rep. Rick Glazier; Rep. Sarah Stevens; Rep. Justin P. Burr
Cc: Gerry Johnson (Sen. Hartsell); Carolyn Gooden (Sen. Apodaca); Anne Murtha (Rep. McCormick); Pamela Ahlin (Rep. Cleveland); Carin Savel (Rep. Glazier); Julie Garrison (Rep. Stevens); Dina Long (Rep. Burr)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Tue, 06-14-2011 at 9:00 AM

Principal Clerk _____
Reading Clerk _____

Time: 9:00am; Room 1124

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
Tuesday	June 14, 2011	9:00 AM	1124 LB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 467	Naturopathic Licensing Act.	Senator Hartsell
HB 622	Nursing Homes/Food Services Inspections.	Senator Apodaca
		Representative McCormick
		Representative Cleveland
		Representative Glazier
		Representative Stevens
HB 809	Model Healthcare-Associated Infections Law.	Representative Burr

Senator Stan Bingham, Co-Chair
Senator Harris Blake, Co-Chair
Senator Louis Pate, Co-Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, June 14, 2011

Room 1124

9:00 AM

Senator Louis Pate, Presiding

AGENDA

WELCOME AND OPENING REMARKS

BILLS TO BE CONSIDERED

SB 467 Naturopathic Licensing Act

HB 622 Nursing Homes/Food Services Inspections

HB 809 Model Healthcare-Associated Infections Law

BILL SPONSORS

Sen. Hartsell
Sen. Apodaca

Rep. McCormick
Rep. Cleveland
Rep. Glazier
Rep. Stevens

Rep. Burr

**OTHER BUSINESS
ADJOURNMENT**

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Tuesday, June 14, 2011

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

FAVORABLE

H.B.(CS #2) 622	Nursing Homes/Food Services Inspections.
	Sequential Referral: None
	Recommended Referral: None
H.B.(CS #1) 678	Pilot Release of Inmates to Adult Care Homes.
	Sequential Referral: None
	Recommended Referral: None

FAVORABLE, AS AMENDED

H.B.(CS #1) 809	Model Healthcare-Associated Infections Law.
	Sequential Referral: None
	Recommended Referral: None
	Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comments:

Sen. Pate for HB 809, HB 678 and HB 622

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Stan Bingham, Co-Chair

Senator Harris Blake, Co-Chair

Senator Louis Pate, Co-Chair

Tuesday, June 14, 2011

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

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

S.B.	467	Naturopathic Licensing Act.	
		Draft Number:	pcs35282
		Sequential Referral:	None
		Recommended Referral:	Finance
		Long Title Amended:	No

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE
AS TO SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1) 677	Discharge of Adult Care Home Residents.	
	Draft Number:	pcs70252
	Sequential Referral:	None
	Recommended Referral:	None
	Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

Health Care Report Two

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

4

HOUSE BILL 622
Committee Substitute Favorable 6/2/11
Committee Substitute #2 Favorable 6/7/11
Fourth Edition Engrossed 6/7/11

Short Title: Nursing Homes/Food Service Inspections.

(Public)

Sponsors:

Referred to:

April 6, 2011

1 A BILL TO BE ENTITLED
2 AN ACT RELATING TO THE FREQUENCY OF FOOD SERVICE INSPECTIONS IN
3 NURSING HOMES AND NURSING HOME BEDS LICENSED UNDER CHAPTER
4 131E OF THE GENERAL STATUTES THAT ARE ALSO CERTIFIED BY MEDICARE
5 AND MEDICAID.

6 The General Assembly of North Carolina enacts:

7 SECTION 1. G.S. 130A-235 is amended by adding a new subsection to read:
8 "§ 130A-235. Regulation of sanitation in institutions; setback requirements applicable to
9 certain water supply wells.

10 (a) For protection of the public health, the Commission shall adopt rules to establish
11 sanitation requirements for all institutions and facilities at which individuals are provided room
12 or board and for which a license to operate is required to be obtained or a certificate for
13 payment is obtained from the Department. The rules shall also apply to facilities that provide
14 room and board to individuals but are exempt from licensure under G.S. 131D-10.4(1). No
15 other State agency may adopt rules to establish sanitation requirements for these institutions
16 and facilities. The Department shall issue a license to operate or a certificate for payment to
17 such an institution or facility only upon compliance with all applicable sanitation rules of the
18 Commission, and the Department may suspend or revoke a license or a certificate for payment
19 for violation of these rules. In adopting rules pursuant to this section, the Commission shall
20 define categories of standards to which such institutions and facilities shall be subject and shall
21 establish criteria for the placement of any such institution or facility into one of the categories.
22 This section shall not apply to State institutions and facilities subject to inspection under
23 G.S. 130A-5(10). This section shall not apply to a single-family dwelling that is used for a
24 family foster home or a therapeutic foster home, as those terms are defined in G.S. 131D-10.2.

25 (a1) Notwithstanding any law, rule, or policy to the contrary, the frequency of food
26 service inspections in nursing homes or nursing home beds licensed under Part 1 of Article 5 of
27 Chapter 131E of the General Statutes or Part 1 of Article 6 of Chapter 131E of the General
28 Statutes that are also certified by the Centers for Medicare and Medicaid Services shall be
29 reduced to a minimum of two inspections per year until October 1, 2012, and thereafter reduced
30 to a minimum of one inspection per year, if the facility achieves a grade 'A' sanitation score. If
31 the facility receives a grade "B" or lower on its annual food service inspection, the county may
32 conduct inspections until the food service operation achieves a grade "A" sanitation score.
33 Nothing in this section prohibits the county from conducting an evaluation or inspection in
34 response to a complaint or in the interest of public safety.



1 (b) Rules that establish a minimum distance from a building foundation for a water
2 supply well shall provide that an institution or facility located in a single-family dwelling
3 served by a water supply well that is located closer to a building foundation than the minimum
4 distance specified in the rules may be licensed or approved if the results of water testing meet
5 or exceed standards established by the Commission and there are no other potential health
6 hazards associated with the well. At the time of application for licensure or approval, water
7 shall be sampled and tested for pesticides, nitrates, and bacteria. Thereafter, water shall be
8 sampled and tested at intervals determined by the Commission but not less than annually. A
9 registered sanitarian or other health official who is qualified by training and experience shall
10 collect the water samples as required by this subsection and may examine the well location to
11 determine if there are other potential health hazards associated with the well. A well shall
12 comply with all other applicable sanitation requirements established by the Commission.

13 (c) The Department may suspend or revoke a license or approval for a violation of this
14 section or rules adopted by the Commission."

15 **SECTION 2.** This act becomes effective October 1, 2011.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011**

H

2

**HOUSE BILL 678
Committee Substitute Favorable 6/7/11**

Short Title: Pilot Release of Inmates to Adult Care Homes.

(Public)

Sponsors:

Referred to:

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN
COLLABORATION WITH THE DEPARTMENT OF CORRECTION, TO ESTABLISH
A PILOT PROGRAM TO ALLOW CERTAIN INMATES RELEASED FROM
CONFINEMENT TO BE PLACED IN ADULT CARE HOMES TO RECEIVE
PERSONAL CARE SERVICES AND MEDICATION MANAGEMENT.

The General Assembly of North Carolina enacts:

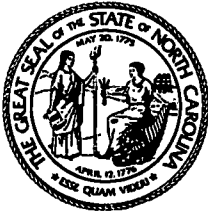
SECTION 1. The Department of Health and Human Services, in collaboration with
the Department of Correction, shall establish a pilot program to allow certain inmates released
from confinement pursuant to G.S. 148-4 or Article 84B of Chapter 15A of the General
Statutes, who have been determined by the Department of Correction to be in need of personal
care services and medication management, to be placed in an adult care home licensed under
Article 1 of Chapter 131D of the General Statutes. The purpose of the pilot program is to
determine if placing this population of released inmates in an adult care home provides the
State with a lower cost alternative to providing for their care upon release from confinement
without jeopardizing the health and safety of the inmates or the public. The Department of
Health and Human Services shall select one adult care home to participate in the pilot program.
The selected adult care home is prohibited from having or admitting any residents other than
the inmates selected to participate in the pilot program. The Secretary of Health and Human
Services may waive any rule adopted under Article 1 or Article 3 of Chapter 131D of the
General Statutes as necessary to protect the public health and safety.

SECTION 2. Not later than 18 months after the participating adult care home
admits its first resident in accordance with the pilot program established under Section 1 of this
act, the Department of Health and Human Services and the Department of Correction shall
report their findings and recommendations to the Joint Legislative Corrections, Crime Control,
and Juvenile Justice Oversight Committee. The report shall include an analysis of the costs and
benefits of allowing this population of released inmates to be placed in an adult care home
setting as compared to continuing their incarceration in a unit of the State prison system.

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



* H 6 7 8 - V - 2 *



HOUSE BILL 678: Pilot Release of Inmates to Adult Care Homes

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Rep. Lewis
Analysis of: Second Edition

Date: June 14, 2011
Prepared by: Shawn Parker
Committee Counsel

SUMMARY: *House Bill 678 would direct the Department of Health and Human Services (DHHS), in collaboration with the Department of Correction (DOC), to establish a pilot program to allow certain inmates released from confinement, who have been determined by the Department of Correction to be in need of personal care services and medication management, to be placed in an adult care home*

CURRENT LAW:

Under G.S. 148-4, the Secretary of Correction can authorize prisoners, under prescribed conditions, to leave their place of confinement to obtain medical services not otherwise available, or, in the case of terminally ill or permanently and totally disabled inmates who no longer pose a significant safety risk, to receive palliative care.

DOC is required under Article 84B of G.S. Chapter 15A to administer a medical release program. Inmates may be considered for medical release from DOC if they meet certain criteria, are geriatric, permanently and totally disabled, or terminally ill, and do not pose a public safety risk. Inmates convicted of a capital felony, a Class A, B1, or B2 felony, or an offense requiring registration as a sex offender are not eligible for medical release. The Post-Release Supervision and Parole Commission determines whether medical release is to be granted and sets conditions of medical release.

An adult care home is defined as, "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." G.S. 131D-2.1.

BILL ANALYSIS: House Bill 678 would establish a pilot program to address needs of inmates granted a release from confinement under G.S. 148-4 or who receive a medical release from DOC and need personal care services and medication management. DHHS would select one adult care home in the State to participate in the pilot program. The home would be prohibited from having or admitting any residents other than the selected inmates. The DHHS Secretary would have the discretion to waive any rules relating to inspection and licensing of facilities necessary to protect public health and safety. DHHS and DOC would be required to report cost/benefit findings and recommendations to the Joint Legislative Corrections, Crime Control, and Juvenile Justice oversight Committee not later than 18 months after the participating home admits its first resident.

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

Jan Paul, counsel to House Health, substantially contributed to this summary.

H678-SMSQ-50(e2) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

2

HOUSE BILL 809
Committee Substitute Favorable 6/7/11

Short Title: Model Health Care-Associated Infections Law.

(Public)

Sponsors:

Referred to:

April 7, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
3 ESTABLISH A STATEWIDE SURVEILLANCE AND REPORTING SYSTEM FOR
4 HEALTH CARE-ASSOCIATED INFECTIONS AND TO SUBJECT HOSPITALS TO
5 THE REQUIREMENTS OF THE STATEWIDE SURVEILLANCE AND REPORTING
6 SYSTEM.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. Article 6 of Chapter 130A of the General Statutes is amended by
9 adding a new Part to read:

10 "Part 1A. Health Care-Associated Infections.

11 "§ 130A-150. Statewide surveillance and reporting system.

12 (a) By December 31, 2011, the Department, in consultation with the State HAI
13 Advisory Group and in accordance with rules adopted by the Commission pursuant to
14 subsection (b) of this section, shall establish a statewide surveillance and reporting system for
15 specified health care-associated infections.

16 (b) The Commission shall adopt rules necessary to implement the statewide
17 surveillance and reporting system established pursuant to subsection (a) of this section. The
18 rules shall specify uniform standards for surveillance and reporting of specified health
19 care-associated infections under the statewide surveillance and reporting system. The uniform
20 standards shall include at least all of the following:

21 (1) A preference for electronic surveillance of specified health care-associated
22 infections to the greatest extent practicable.

23 (2) A requirement for electronic reporting of specified health care-associated
24 infections.

25 (c) Each hospital, as defined in G.S. 131E-76(3), is subject to the statewide surveillance
26 and reporting system established in accordance with subsection (a) of this section and shall be
27 responsible for health care-associated infections surveillance and reporting of specified health
28 care-associated infections data to the Department through the Centers for Disease Control and
29 Prevention National Health Care Safety Network.

30 (d) The Department shall release to the public aggregated and provider-specific data on
31 health care-associated infections that does not contain social security numbers or other personal
32 identifying information only if it deems the release of this data to be reliable and necessary to
33 protect the public's health."

34 SECTION 2. Not later than December 31, 2011, and annually thereafter, the State
35 Department of Health and Human Services shall report to the General Assembly on its efforts
36 related to the North Carolina State Plan on Healthcare Associated Infections or any other matter



* H 809 - V - 2 *

1 it considers relating to Healthcare Associated Infections. The State HAI Advisory Group shall
2 advise the Department on whether current science and processes are available to adequately
3 gather and report to the public infection rates and implementation of infection prevention
4 controls, which include providing provider specific information that does not contain
5 patient-identifiable information and accounts for appropriate risk adjustment specific to the
6 provider, and whether current federal or State licensure, accreditation, or other standards are
7 appropriate to foster an appropriate and adequate infection control system in health care
8 settings, beginning its review with hospitals and ambulatory surgery centers. The Department
9 shall include in its annual report findings, recommendations, and any suggested legislation.
10 **SECTION 3.** This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S

D

SENATE BILL 467
PROPOSED COMMITTEE SUBSTITUTE S467-CSSQ-49 [v.7]

6/13/2011 7:53:28 PM

Short Title: Naturopathic Licensing Act.

(Public)

Sponsors:

Referred to:

March 31, 2011

1 A BILL TO BE ENTITLED
2 AN ACT TO ESTABLISH THE NORTH CAROLINA NATUROPATHIC DOCTORS
3 LICENSURE ACT.

4 The General Assembly of North Carolina enacts:

5 SECTION 1. Chapter 90 of the General Statutes is amended by adding a new
6 Article to read:

7 "Article 43.

8 "Naturopathic Doctors.

9 "§ 90-730. Short title.

10 This Article may be cited as the 'North Carolina Naturopathic Doctors Licensure Act.'

11 "§ 90-731. Intent; purpose.

12 (a) Intent. – The General Assembly finds that a significant number of residents of the
13 State of North Carolina choose complementary and alternative health care and declares that
14 naturopathic treatment is a distinct health care profession that affects the public health, safety,
15 and welfare and provides for choices in health care. The General Assembly concludes that
16 licensure is in the current interest of North Carolina citizens to aid in protecting citizens from
17 deception, fraud, and damage to their health status. Licensure can provide a process in which
18 citizens may more confidently rely on the level of skill, education, and competency possessed
19 by licensed persons.

20 (b) Purpose. – The purpose of this Article is to provide standards for the licensure of
21 naturopathic doctors desiring to practice naturopathic medicine in this State and to ensure the
22 maintenance of professional competence and acceptable standards of practice.

23 "§ 90-732. Definitions.

24 The following definitions apply in this Article:

25 (1) Approved program of naturopathic medicine. – A program that meets all of
26 the following conditions:

27 a. A program that provides graduate level full-time didactic and
28 supervised clinical training that is accredited, or has achieved
29 candidacy status for accreditation, by the Council on Naturopathic
30 Medical Education Program or its federally recognized successor
31 agency.



- b. A program that is offered by an institution of higher education that is accredited by a regional or national institutional accrediting agency recognized by the United States Secretary of Education.
- c. If the program is offered in the United States, a program that awards the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. If the program is offered in Canada, a program that awards the degree or diploma of Doctor of Naturopathy or Doctor of Naturopathic Medicine, and is offered by an institution of higher education that has provincial approval for participation in government-funded student aid programs.
- (2) Board. – The North Carolina Naturopathic Doctors Licensing Board.
- (3) Criminal history. – A history of conviction of a State or federal crime, whether a misdemeanor or felony.
- (4) Integrative medicine. – As defined in G.S. 90-1.1(3).
- (5) Natural medicines. – Any herbal, nutritional, supplemental, homeopathic, or other nonprescription remedies.
- (6) Naturopathic medicine. – A system of natural health care that employs diagnosis and treatment using natural therapies and diagnostic techniques for the promotion, maintenance, and restoration of health and the prevention of disease, including the following:
- a. Administering or providing any of the following for preventive and therapeutic purposes: natural medicines, natural therapies, natural topical medicines, hydrotherapy, dietary therapy, and naturopathic physical medicine.
- b. Using diagnostic procedures, including physical and orificial examination, but excluding endoscopy, sigmoidoscopy, and colonoscopy.
- c. Ordering and interpreting laboratory tests and diagnostic imaging, but excluding electrocardiograms, echocardiograms, electroencephalograms, nuclear imagings, MRIs, CT scans, and other tests that should be conducted and interpreted by a physician licensed under Article 1 of this Chapter.
- (7) Naturopathic physical medicine. – The manual use of massage, stretching, or resistance.
- (8) Naturopathic doctor. – A person licensed to practice naturopathic medicine under this Article.

"§ 90-733. Practice of naturopathic medicine; scope of practice.

(a) Practice of Naturopathic Medicine. – A naturopathic doctor is a licensed health care provider having the same responsibilities as other licensed doctors regarding public health laws, reportable diseases and conditions, communicable disease control and prevention, and the recording of vital statistics. In diagnosing and treating an individual, a naturopathic doctor may employ the following therapies, modalities, procedures, or remedies consistent with naturopathic education and training:

- (1) Dispense, administer, and advise the use of natural remedies derived from or substantially similar in molecular structure or function to natural sources for preventive and therapeutic purposes, including food, extracts of food, nutraceuticals, vitamins, minerals, enzymes, botanicals and their extracts, homeopathic remedies prepared according to the Homeopathic Pharmacopoeia of the United States, and all dietary supplements and

nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. § 301, et seq.

(2) Order and perform physical examinations.

(3) Order, perform, and interpret laboratory examinations and diagnostic imaging studies.

(4) Perform hot or cold hydrotherapy, naturopathic physical treatment, electromagnetic energy, and therapeutic exercise.

(5) Perform health education and health counseling.

(6) Perform utilization routes of administration, including oral, nasal, auricular, ocular, rectal, vaginal, and transdermal.

(7) Perform, repair, and care incidental to superficial lacerations and abrasions and apply topical and local anesthetics and antimicrobials.

(8) Remove foreign bodies located in the superficial tissues.

(b) Prohibitions. – A naturopathic doctor may not perform any of the following functions unless otherwise licensed by this State to do so:

(1) Prescribe, dispense, or administer any legend drug, except as authorized by this Article.

(2) Practice or attempt to practice as a medical physician, osteopath, acupuncturist, dentist, podiatrist, optometrist, chiropractor, dietitian or nutritionist, psychologist, advanced practice registered nurse, physician assistant, physical therapist, or any other health care professional not authorized by this Article.

(3) Use general or spinal anesthetics.

(4) Perform procedures using a laser device.

(5) Perform surgical procedures.

(6) Administer ionizing radioactive substances for therapeutic purposes.

(7) Perform chiropractic adjustments.

(8) Perform acupuncture.

"§ 90-734. License required; exemptions.

(a) License Required. – On or after January 1, 2012, no person shall practice or offer to practice as a naturopathic doctor, perform naturopathic medicine, or use any card, title, or abbreviation to indicate that the person is a naturopathic doctor unless the person has been licensed under the provisions of this Article. Persons licensed under this Article have the exclusive right to use the titles 'Naturopathic Doctor,' 'Doctor of Naturopathic Medicine,' 'Doctor of Naturopathy,' 'Naturopathic Medicine,' 'Naturopath,' or the abbreviations 'D.N.,' 'N.D.,' 'ND,' and 'D.N.M.'

(b) Exemptions. – Nothing in this Article shall be construed to prohibit or affect any of the following:

(1) The practice of a profession by an individual who is licensed, certified, or registered under other laws of this State and is performing services within the authorized scope of practice.

(2) The practice of naturopathic medicine by a person employed by the federal government while the person is engaged in the performance of duties prescribed by laws and regulations of the United States.

(3) A person rendering aid in an emergency situation when no fee or other compensation for the service is received.

(4) The practice of naturopathic medicine by a naturopathic doctor duly licensed in another state, territory, or the District of Columbia when called into this State to consult with a licensed physician for a period not to exceed six months.

(5) The practice of naturopathic medicine by students completing a clinical requirement for graduation from a naturopathic training program approved by the Board, so long as the practice is performed under the supervision of a physician licensed under Article 1 of this Chapter and the clinical requirement does not exceed one year.

(6) A person who does not hold himself or herself out to be a naturopathic doctor when that person furnishes information to customers or sells, administers, or utilizes nutritional supplements, herbs, food, homeopathic preparations, and such physical forces as heat, cold, water, touch, and light at the person's retail, health spa, or health consulting establishment.

(c) Unlawful Act. – A person who violates this section is guilty of a Class 1 misdemeanor. The Board may make application to superior court for an order enjoining a violation of this section. Upon a showing by the Board that a person has violated or is about to violate this section, the court may grant an injunction, restraining order, or take other appropriate action.

"§ 90-735. North Carolina Naturopathic Doctors Licensing Board.

(a) Board. – The North Carolina Naturopathic Doctors Licensing Board is created. The Board consists of seven members serving for staggered terms. The initial Board members shall be appointed on or before January 1, 2012, as follows:

(1) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint two naturopathic doctors who are licensed under this Article. One member shall serve a term of one year and one member shall serve a term of three years.

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint two naturopathic doctors who are licensed under this Article. One member shall serve a term of one year and one member shall serve a term of two years.

(3) The Governor shall appoint two physicians licensed under Article 1 of Chapter 90 of the General Statutes, at least one of whom shall be involved in the practice of integrative medicine or who teaches integrative medicine at a medical school. Both of these members shall serve a term of three years.

(4) The Governor shall appoint for a two-year term a public member who is not a licensed health care professional and is not employed in a health care profession.

Upon the expiration of the terms of the initial Board members, each member is appointed for a term of three years, beginning on January 1 of each year. A member serves until the member's successor is appointed. No member shall serve on the Board for more than two consecutive terms.

(b) Vacancies. – A member of the Board serves at the pleasure of the authority that appointed the member. A vacancy shall be filled in the same manner as the original appointment. An appointee to fill a vacancy shall serve the remainder of the unexpired term and until the appointee's successor has been duly appointed.

(c) Removal. – The Board may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings as a licensee shall be disqualified from participating in the official business of the Board until the charges have been resolved.

(d) General Administration. – A Board member may not receive compensation but may receive reimbursement as provided in G.S. 93B-5. The officers of the Board include a chair, a secretary, and any other officer deemed necessary by the Board to carry out the purposes of this Article. All officers shall be elected annually by the Board at its first meeting held after

1 appointments to the Board are made. The Board shall hold a meeting within 45 days of the
2 appointment of new Board members. All officers shall serve one-year terms and shall serve
3 until their successors are elected and qualified. No person shall chair the Board for more than
4 five consecutive years. The Board may adopt rules governing the calling, holding, and
5 conducting of regular and special meetings. A majority of Board members constitutes a
6 quorum.

7 **"§ 90-736. Powers of the Board.**

8 The Board shall have the following powers and duties:

- 9 (1) Administer and enforce the provisions of this Article.
- 10 (2) Adopt rules as may be necessary to carry out the provisions of this Article.
- 11 (3) Establish, examine, and determine the qualifications and fitness of applicants
12 for licensure and renewal of licensure.
- 13 (4) Issue, renew, deny, suspend, or revoke licenses and conduct any disciplinary
14 actions authorized by this Article.
- 15 (5) Collect fees for licensure, licensure renewal, and other services deemed
16 necessary to carry out the provisions of this Article.
- 17 (6) Establish and approve continuing education requirements for persons
18 licensed under this Article.
- 19 (7) Employ and fix the compensation of personnel that the Board determines is
20 necessary to carry out the provisions of this Article and incur other expenses
21 necessary to perform the duties of the Board.
- 22 (8) Adopt a seal containing the name of the Board for use on all licenses and
23 official reports issued by the Board.
- 24 (9) Institute corrective measures, as necessary, to rehabilitate naturopathic
25 doctors or limit their practice.
- 26 (10) Investigate persons engaging in practices which violate the provisions of this
27 Article.

28 **"§ 90-737. Qualifications for licensure; renewal; reinstatement.**

29 (a) Licensure. – Upon application to the Board and payment of the required fees, an
30 applicant may be licensed under this Article as a naturopathic doctor if the applicant meets all
31 of the following qualifications and conditions:

- 32 (1) Is of good moral and ethical character.
- 33 (2) Is a graduate of an approved program of naturopathic medicine.
- 34 (3) Meets one of the following two conditions:
 - 35 a. Has successfully passed a competency-based national naturopathic
36 licensing examination administered by the North American Board of
37 Naturopathic Examiners, or equivalent agency as recognized by the
38 Board.
 - 39 b. Has successfully passed a competency-based examination approved
40 by the Board and by the North American Board of Naturopathic
41 Medical Education or its successor agency.
- 42 (4) Provides the Board with a list of physicians licensed to practice medicine in
43 this State who have agreed to work with the applicant and accept referrals
44 from the applicant. The applicant shall also provide the Board with letters of
45 verification from the listed physicians. The list shall include physicians with
46 specialties in at least four of the following areas: allergy and immunology,
47 cancer and oncology, cardiology, endocrinology and metabolism, family
48 medicine, gastroenterology, internal medicine, obstetrics and gynecology,
49 pediatrics, psychiatry, and urology.

(5) Submits any other documentation the Board deems necessary to determine the applicant's fitness for licensure under this Article. This documentation may include successful completion of a Board-approved examination on State laws and rules related to naturopathic medicine.

(b) Renewal. – A license expires two years after the date it is issued unless it is renewed. Failure to renew a license within six months of the date the license expires shall result in automatic forfeiture of the right to practice naturopathic medicine in this State until such time that the license has been reinstated. To renew a license, a licensee shall meet all of the following conditions:

(1) Submit an application for license renewal.

(2) Pay the required fees.

(3) Complete at least 40 hours of continuing education approved by the Board within a two-year period.

(c) Reinstatement. – A licensed naturopathic doctor who has allowed the license to lapse by failure to renew within the time allowed under subsection (b) of this section may apply for reinstatement. The Board may reinstate the applicant's license if the applicant pays the required fees, furnishes a statement of the reason for failure to apply for renewal before the deadline, and complies with any other requirements established in rules adopted by the Board. If the license has lapsed for five years or longer, the Board may require the applicant to satisfactorily complete a refresher course approved by the Board or to provide proof of active licensure within the past five years in another jurisdiction.

"§ 90-738. Reciprocity.

The Board may grant, upon application and payment of fees, a license to a person who resides in this State and has been licensed to practice as a naturopathic doctor in another state or a Canadian province if both of the following conditions are met:

(1) The standards for licensure in the state or province in which the naturopathic doctor is licensed are substantially equivalent to those provided in this Article.

(2) The applicant provides proof of licensure in good standing in all states and provinces in which the applicant has been licensed.

"§ 90-739. Fees.

The Board may impose the following fees:

(1) Application and examination \$200.00

(2) License \$600.00

(3) License renewal \$400.00

(4) Late renewal \$200.00

(5) Reinstatement \$1,000.00

(6) Reasonable charges for duplication services and material.

(7) Criminal history record check fee equal to the amount imposed by the Department of Justice to conduct the criminal history record check requested by the Board.

"§ 90-740. Disciplinary authority.

(a) Authority. – The Board may impose probationary conditions upon a licensee, or it may deny, suspend, revoke, or refuse to issue or renew a license, if the licensee or applicant does any of the following:

(1) Engages in any act or practice in violation of any of the provisions of this Article or of any of the rules adopted by the Board or aids, abets, or assists any other person in the violation of the provisions of this Article or rules adopted by the Board.

- (2) Gives false information to or withholds information from the Board in procuring or attempting to procure a license.
- (3) Has been convicted of or pled guilty or no contest to a crime that indicates that the person is unfit or incompetent to practice as a naturopathic doctor or that indicates the person has deceived or defrauded the public. A felony conviction shall result in the automatic revocation of a license issued by the Board unless the Board determines otherwise pursuant to rules adopted by the Board.
- (4) Has been declared mentally incompetent by a court of competent jurisdiction.
- (5) Habitually uses or is addicted to drugs or intoxicating liquors to the extent that it affects the licensee's professional competency. If a licensee violates this subdivision, the Board may require the licensee to undergo a mental or physical examination by physicians designated by the Board before or after the licensee has been charged. The results of the examination shall be admissible as evidence in a hearing before the Board.
- (6) Has demonstrated gross negligence, incompetency, or misconduct in the performance of naturopathic medical treatment.
- (7) Has had a health care provider license denied, restricted, revoked, or suspended by another state or jurisdiction.
- (8) Fails to consent to a criminal history record check.
- (9) Fails to respond, within a reasonable time, to inquiries from the Board concerning any matter affecting the individual's license to practice naturopathic medicine.
- (10) Fails to complete continuing education requirements within the time prescribed.

(b) Hearing. – Denial, refusal to renew, suspension, or revocation of a license or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for not less than two years.

(c) Records. – The Board shall keep a record of its proceedings. The Board may, in a closed session, receive evidence regarding the treatment of a patient who has not expressly or impliedly consented to the public disclosure of the treatment when necessary for the protection of the rights of the patient or of the accused naturopathic doctor and the full presentation of relevant evidence. All records, papers, investigative files, investigative reports, and other documents containing information gathered or received by the Board as a result of investigations, inquiries, or interviews conducted in connection with an application for licensure, a complaint, or a disciplinary matter are not considered public documents within the meaning of Chapter 132 of the General Statutes. If a record, paper, or other document containing information collected and compiled by the Board is admitted into evidence in a hearing held by the Board, it shall then be a public record within the meaning of Chapter 132 of the General Statutes.

(d) Confidential Information. – The Board may release confidential or nonpublic information about a licensee to any health care licensure board in this State or another state relating to the issuance, denial, suspension, revocation, or voluntary surrender of the license, including the reasons for the action or any investigative report prepared by the Board. The Board shall notify the naturopathic doctor within 60 days after the information is released. The Board shall furnish to the naturopathic doctor a summary of the information being released. However, if the naturopathic doctor requests, in writing, within 30 days from the date of notice,

1 a copy of the information being released, the Board shall give to the naturopathic doctor a copy
2 of all the information being released. Notice or copies shall not be provided by the Board if the
3 information relates to an ongoing criminal investigation by a law enforcement agency or any
4 Department of Health and Human Services personnel with enforcement or investigative
5 responsibilities.

6 **"§ 90-741. Criminal history record check of applicants and licensees.**

7 (a) Criminal History Record Check. – The Board shall require a criminal history record
8 check for a person who is either licensed under this Article or applying for licensure under this
9 Article. The Board is responsible for providing to the North Carolina Department of Justice the
10 fingerprints of the person to be checked, a form signed by the person consenting to the criminal
11 record check and the use of fingerprints and other identifying information required by the State
12 or National Repositories, and any additional information required by the Department of Justice.
13 The Board shall keep all information obtained pursuant to this section confidential.

14 (b) Conviction. – If a criminal history record check reveals one or more convictions, the
15 conviction does not automatically bar licensure. The Board shall consider all of the following
16 factors regarding the conviction:

17 (1) The level of seriousness of the crime.

18 (2) The date of the crime.

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

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

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

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

25 (7) The subsequent commission of a crime by the person.

26 (c) Denial of Licensure. – If the Board denies, revokes, or suspends a license based on
27 information obtained in a criminal history record check, the Board shall disclose to the person
28 the information contained in the criminal history record check that is relevant to the Board's
29 actions. The Board may not provide a copy of the criminal history record check to the person.
30 A person has the right to appear before the Board to appeal the Board's decision. An
31 appearance before the Board shall constitute an exhaustion of administrative remedies in
32 accordance with Chapter 150B of the General Statutes.

33 (d) Limited Immunity. – The Board, its officers and employees, acting in good faith and
34 in compliance with this section, shall be immune from civil liability for its actions based on
35 information provided in a person's criminal history record check.

36 **"§ 90-742. Reports; immunity from suit.**

37 (a) Report. – A person who has reasonable cause to suspect misconduct or incapacity of
38 a licensee, or who has reasonable cause to suspect that a person is in violation of this Article,
39 may report the relevant facts to the Board. Upon receipt of a charge, or upon its own initiative,
40 the Board may give notice of an administrative hearing or may, after diligent investigation,
41 dismiss unfounded charges. A person who, in good faith, makes a report pursuant to this
42 section is immune from any criminal prosecution or civil liability resulting from making the
43 report.

44 (b) Immunity. – The Board and its staff are immune from any criminal prosecution or
45 civil liability for exercising, in good faith, the powers and duties given to the Board under this
46 Article.

47 **"§ 90-743. Third-party reimbursement.**

48 Nothing in this Article shall be construed to require direct third-party reimbursement to
49 persons licensed under this Article.

50 **"§ 90-744. Advisory Council.**

(a) Created. – An Advisory Council is created to advise the Board and to develop recommendations to foster coordination and collaboration between naturopathic doctors, medical doctors, and other health professionals for the purpose of providing appropriate care for patients. The Council shall meet periodically and report its recommendations to the Board and to the boards of directors for the North Carolina Medical Society and the North Carolina Association of Naturopathic Physicians.

(b) Membership. – The Advisory Council shall consist of the following six members:

(1) Two licensed physicians appointed by the North Carolina Medical Society.

(2) Two licensed naturopathic doctors appointed by the North Carolina Association of Naturopathic Physicians.

(3) One licensed pharmacist or pharmacologist appointed by the North Carolina Association of Pharmacists.

(4) One licensed advanced practice registered nurse appointed by the North Carolina Nursing Association.

(c) General Administration. – Each member is appointed for a term of two years beginning July 1, 2012. A member serves until a successor is appointed. The members of the Advisory Council may elect a chairperson by a majority vote. Advisory Council members may not receive compensation for their services but may receive reimbursement as provided in G.S. 93B-5."

SECTION 2. G.S. 90-18(c) is amended by adding a new subdivision to read:

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

...

(21) The practice of naturopathic medicine by a licensed naturopathic doctor under the provisions of Article 43 of this Chapter."

SECTION 3. Part 2 of Article 4 of Chapter 114 of the General Statutes is amended by adding a new section to read:

"§ 114-19.31. Criminal history record checks for naturopathic doctors.

(a) The Department of Justice shall provide to the North Carolina Naturopathic Doctors Licensing Board from the State and National Repositories of Criminal Histories the criminal history of an applicant for licensure by the Board or a licensee of the Board. The Judicial Department shall provide to the Department of Justice, along with the request, the fingerprints of the applicant or licensee, a form signed by the applicant or licensee consenting to the criminal history record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Justice. The fingerprints of the applicant or licensee shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Judicial Department shall keep all information obtained pursuant to this section confidential.

(b) The Department of Justice may charge a fee to offset the cost incurred by it to conduct a criminal history record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 4. Notwithstanding the provisions of G.S. 90-735, as enacted by Section 1 of this act, the initial naturopathic doctors appointed to the North Carolina Naturopathic Doctors Licensing Board must be North Carolina residents, must be licensed as a naturopathic doctor in a state that licenses this profession, and must be eligible for licensure under G.S. 90-737, as enacted by Section 1 of this act. Upon appointment, the appointee must immediately seek to become licensed under this act.

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



SENATE BILL 467: Naturopathic Licensing Act

2011-2012 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Hartsell, Apodaca
Analysis of: PCS to First Edition
S467-CSSQ-49

Date: June 13, 2011
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 467 would establish the North Carolina Naturopathic Doctors Licensure Act.*

BILL ANALYSIS:

Senate Bill 467 defines "naturopathic medicine" as a system of natural health care that employs diagnosis and treatment using natural therapies and diagnostic techniques for the promotion, maintenance, and restoration of health and the prevention of disease, including the following:

- Administering or providing any of the following for preventative and therapeutic purposes: natural medicines, natural therapies, natural topical medicines, hydrotherapy, dietary therapy, and naturopathic physical medicine.
- Using diagnostic procedures, including physical and orificial examination, but excluding endoscopy, sigmoidoscopy, and colonoscopy.
- Ordering and interpreting laboratory tests and diagnostic imaging, but excluding electrocardiograms, echocardiograms, electroencephalograms, nuclear imaging, MRIs, CT scans, and other tests that should be conducted and interpreted by a licensed physician.

Senate Bill 467 defines the scope of practice of naturopathic medicine and creates a licensure requirement for anyone practicing naturopathic medicine on or after January 1, 2012. Licenses will be granted by the North Carolina Naturopathic Doctors Licensing Board (Board) established in Senate Bill 467. The bill outlines the powers of the Board and the qualifications for licensure, licensure renewal and licensure reinstatement. Criminal history record checks will be required for licensure. The Board is granted disciplinary authority and the hearing process is provided for.

Senate Bill 467 also establishes an Advisory Council to the Board to develop recommendations to foster coordination and collaboration between naturopathic doctors, medical doctors, and other health professionals.

BACKGROUND: Currently, there is no licensure requirement for Naturopathic Doctors in North Carolina. Sixteen states, the District of Columbia, and 4 Canadian provinces have enacted a licensure law for naturopathic doctors.

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

S467-SMTK-50(CSSQ-49) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H

D

HOUSE BILL 677
Committee Substitute Favorable 6/7/11
Third Edition Engrossed 6/7/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H677-PCS70252-SQ-51

Short Title: Discharge of Adult Care Home Residents.

(Public)

Sponsors:

Referred to:

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE ADULT CARE HOMES WITH GREATER FLEXIBILITY IN THE
TRANSFER AND DISCHARGE OF RESIDENTS AND TO ENACT APPEAL RIGHTS
FOR ADULT CARE HOME RESIDENTS AND ADULT CARE HOMES WITH
RESPECT TO DISCHARGE DECISIONS AND TO CREATE ADULT CARE HOME
RESIDENT DISCHARGE TEAMS WITHIN EVERY COUNTY WHICH CONTAINS
AN ADULT CARE HOME LICENSED UNDER CHAPTER 131D OF THE GENERAL
STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.1 is amended by adding two new subdivisions to read:

"(16) Hearing Unit. – The chief hearing officer within the Division of Medical Assistance designated to preside over hearings regarding the transfer and discharge of adult care home residents, and the chief hearing officer's staff.

(17) Adult care home resident discharge team. – A team consisting of one member from the department of social services and one member from the local management entity responsible for assisting in finding an appropriate placement for discharged residents, as established by the county department of social services in every county which contains an adult care home licensed under this Chapter."

SECTION 2. G.S. 131D-4.5(5) reads as rewritten:

"(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes. residents for safe and orderly transfer and discharge."

SECTION 3. G.S. 131D-21(17) reads as rewritten:

"(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of



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the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes. residents for safe and orderly transfer and discharge."

SECTION 4. Article 1 of Chapter 131D of the General Statutes is amended by adding a new section to read:

"§ 131D-4.8. Discharge of residents; appeals.

(a) An adult care home may initiate discharge of a resident based on any of the following reasons:

- (1) The discharge is necessary to protect the welfare of the resident and the adult care home cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner.
- (2) The health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the adult care home, as documented by the resident's physician, physician assistant, or nurse practitioner.
- (3) The safety of the resident or other individuals in the adult care home is endangered.
- (4) The health of the resident or other individuals in the adult care home is endangered, as documented by a physician, physician assistant, or nurse practitioner.
- (5) The resident has failed to pay the costs of services and accommodations by the payment due date specified in the resident's contract with the adult care home, after receiving written notice of warning of discharge for failure to pay.
- (6) The discharge is mandated under this Article, Article 3 of this Chapter, or rules adopted by the Medical Care Commission.

(b) Upon arrival at any adult care home, an individual must be identified to receive a discharge notice on behalf of the resident. An adult care home shall notify a resident, the resident's legal representative, and the individual identified to receive a discharge notice of its intent to initiate the discharge of the resident under subsection (a) of this section, in writing, at least 30 days before the resident is discharged. The written notice shall include (i) the reasons for the discharge, (ii) an appropriate discharge destination if known, (iii) personal medical care information relating to the resident, as required by the Department, (iv) a copy of the Adult Care Home Notice of Discharge, (v) a copy of the Adult Care Home Hearing Request Form, and (vi) other information, as required under rules adopted by the Medical Care Commission. If a discharge is initiated under subdivision (a)(1) of this section on the basis that a resident's physician requires a different level of care for the resident, the discharge is not subject to appeal for that specific reason unless there is a documented conflict between two or more of the resident's physicians regarding the resident's appropriate level of care but remains subject to appeal on all other available grounds.

(c) During any appeal of a discharge to the Hearing Unit, if the Hearing Unit determines that the discharge destination identified in the written notice required by subsection (b) of this section does not include an appropriate discharge destination, the Department shall not prohibit discharge solely for that reason.

(d) If an adult care home resident or the resident's legal representative elects to appeal a discharge initiated by the adult care home, the appeal shall be to the Hearing Unit. The Hearing Unit shall decide all appeals pertaining to the discharge of adult care home residents. The decision of the Hearing Unit is the final agency decision. Any person aggrieved by a decision of the Hearing Unit pertaining to an adult care home resident discharge is entitled to immediate judicial review of the decision in Wake County Superior Court or in the superior court of the county where the person resides. The appellant shall file a petition for judicial review not later than 30 days after the person is served with a written copy of the Hearing Unit decision. Within 10 days after the petition for judicial review is filed with the superior court, the appellant shall serve copies of the petition by personal service or certified mail upon all parties who were parties of record to the appeal to the Hearing Unit. Other parties to the appeal to the Hearing Unit may file a response to the petition within 30 days after service. The Department as the decision maker in the appeal to the Hearing Unit is not a party of record. Within 30 days after receipt of a petition for judicial review, the Department shall transmit to the superior court the original or a certified copy of the official record in the appeal to the Hearing Unit, together with the final agency decision. In reviewing the Department's final decision, the superior court shall review the official record, de novo, and make findings of fact and conclusions of law. The decision of the Department remains in effect during the pendency of review by the superior court and any further review in the appellate courts.

(e) The facility shall convene the adult care home resident discharge team to assist with finding a placement for a resident if, at the time of notice of discharge, the destination is unknown, or the destination is not appropriate for the resident. The facility is not solely responsible for securing an appropriate discharge destination. Local management entities shall take the lead role for the discharge destination for those residents whose primary unmet needs are related to mental health, developmental disabilities, or substance abuse and who meet the criteria for the target population established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Local departments of social services shall take the lead role for those residents whose primary unmet needs are related to health, including Alzheimer's disease and other forms of dementia, welfare, abuse, or neglect. When the adult care home resident discharge team is convened at the request of a facility, the adult care home resident discharge team shall consult with that facility, as well as the resident receiving the discharge notice and that resident's legal representative. Upon the request of the resident or the resident's legal representative, the Regional Long-Term Care Ombudsman shall serve as a member of the adult care home resident discharge team. The facility requesting the adult care home resident discharge team to be convened shall notify the resident and the resident's legal representative of this right. The adult care home resident discharge team shall provide the Hearing Unit with the discharge location at or before the discharge hearing.

(f) Meetings of the adult care home resident discharge team are not subject to the provisions of Article 33C of Chapter 143 of the General Statutes. All information and records acquired by the adult care home resident discharge team in the exercise of its duties are confidential unless all parties give written consent to the release of that information.

(g) If a discharge is under appeal to the Hearing Unit, the resident shall remain in the facility and shall not be subject to discharge until issuance of the decision of the Hearing Unit with the following exceptions:

- (1) The discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant, or nurse practitioner;
- (2) The safety of other individuals in the facility is endangered;
- (3) The health of other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner; or

1 (4) Failure to pay costs of services and accommodations by the payment due
2 date according to the resident contract after receiving a 30-day written notice
3 of warning of discharge for failure to pay."

4 **SECTION 5.** G.S. 150B-1(e) is amended by adding a new subdivision to read:

5 "(18) Hearings provided by the Department of Health and Human Services to
6 decide appeals pertaining to adult care home resident discharges initiated by
7 adult care homes under G.S. 131D-4.8."

8 **SECTION 6.** This act becomes effective October 1, 2011.

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Senate Health Care

Name of Committee

06/14/11

Date

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VISITOR REGISTRATION SHEET

Senate Health Care

Name of Committee

06/14/11

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Carolines Health Care

Scott Furney, MD

Carolines Health Care

Box #	Year	Chamber	Committee
12	2011-2012	Senate	Insurance
12	2011-2012	Senate	Judiciary I
12	2011-2012	Senate	Judiciary II
12	2011-2012	Senate	Mental Health & Youth Services