

2013-2014

**SENATE
HEALTH CARE**

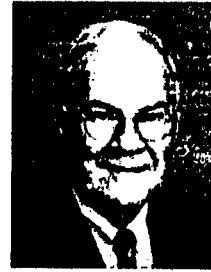
MINUTES

NORTH CAROLINA GENERAL ASSEMBLY

**Health Care
2013 – 2014 SESSION**



**Senator Ralph Hise
Co-Chair**



**Senator Louis Pate
Co-Chair**



**Senator Jeff Tarte
Vice chair**



Senator Austin Allran



Senator Chad Barefoot



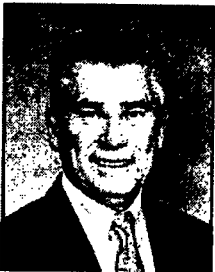
Senator Stan Bingham



Senator David Curtis



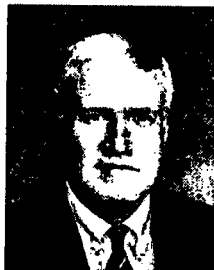
Senator Don Davis



Senator James Davis



Senator Fletcher Hartsell



Senator Neal Hunt



Senator Eleanor Kinnaird



Senator Floyd McKissick



Senator Earline Parmon



Senator Ronald Rabin



Senator Shirley Randleman



Senator Gladys Robinson



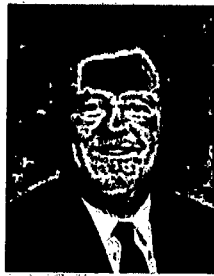
Senator Robert Rucho

NORTH CAROLINA GENERAL ASSEMBLY

**Health Care
2013 – 2014 SESSION**



Senator Joshua Stein



Senator Tommy Tucker



Senator Trudy Wade



Senator Mike Woodard

Senate Committee on Health Care
Wednesday, March 13, 2013
11:00 AM
Room 544 LOB

Senator Ralph Hise, Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	BILL SPONSOR
SB 223	Severance & Relocation For Area Directors.	Senator Hise
SB 208	Effective Operation of 1915(b)/(c) Waiver.	Senator Tucker Senator Barringer

Other Business

Adjournment

Senate Committee on Health Care
Wednesday, March 13, 2013 at 11:00 AM
Room 544 of the Legislative Office Building

MINUTES

Senator Ralph Hise, Chair, presided.

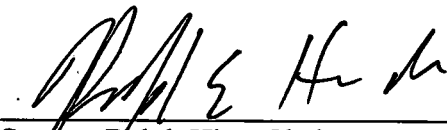
The Senate Committee on Health Care met at 11:00 AM on March 13, 2013, in Room 544 of the Legislative Office Building. Seventeen members were present.

Senator Hise called the meeting to order by welcoming everyone and recognizing the Pages—Emma Burri of Mecklenburg County, Lance Hunter of Wake County, and Jessica Joyner of Wake County—and the Sergeants-at-Arms—Steve Wilson, Ed Kesler, and Billy Fritscher.

Senator Hise explained Senate Bill 223 – Severance & Relocation for Area Directors. After a time for questions and answers, Senator Wade made a motion for a favorable report. The bill passed and was referred to Appropriations/Base Budget.

Senator Tucker was recognized to present Senate Bill 208 – Effective Operation of 1915(b)/(c) Waiver. Senator Tucker noted problems and issues with the bill as currently written, then withdrew the bill.

The meeting adjourned at 11:40 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
It: Tuesday, March 12, 2013 11:17 AM
to: Sen. Ralph Hise; Sen. Tommy Tucker; Sen. Tamara Barringer
Cc: Susan Fanning (Sen. Ralph Hise); Joseph Stansbury (Sen. Tommy Tucker); Gloria Whitehead (Sen. Tamara Barringer)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wednesday, March 13, 2013 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 13, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 223	Severance & Relocation For Area Directors.	Senator Hise
SB 208	Effective Operation of 1915(b)/(c) Waiver.	Senator Tucker Senator Barringer

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, March 13, 2013

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

FAVORABLE

SB . 223

Severance & Relocation For Area Directors.

Draft Number: None

Sequential Referral: Appropriations/Base Budget

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Senator Ralph Hise will handle SB 223



* C M R 1 1 4 - V - 1 *

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

1

SENATE BILL 223

Short Title: Severance & Relocation For Area Directors.

(Public)

Sponsors: Senator Hise (Primary Sponsor).

Referred to: Health Care.

March 7, 2013

A BILL TO BE ENTITLED

AN ACT TO ALLOW AREA BOARDS TO OFFER APPLICANTS FOR THE POSITION OF
AREA DIRECTOR SEVERANCE BENEFITS AND RELOCATION EXPENSES AS AN
INCENTIVE FOR ACCEPTING AN OFFER OF EMPLOYMENT.

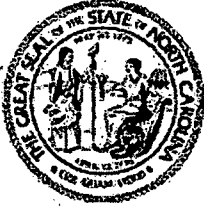
The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-121(a2) reads as rewritten:

"(a2) The area board shall not provide the director with any benefits that are not also provided by the area board to all permanent employees of the area ~~program-program~~, except that the area board may, in its discretion, offer severance benefits, relocation expenses, or both, to an applicant for the position of director as an incentive for the applicant to accept an offer of employment. The director shall be reimbursed only for allowable employment-related expenses at the same rate and in the same manner as other employees of the area program."

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





SENATE BILL 223: Severance & Relocation For Area Directors

2013-2014 General Assembly

Committee:	Senate Ref to Health Care: If fav, re-ref to Appropriations/Base Budget	Date:	March 7, 2013
Introduced by:	Sen. Hise	Prepared by:	Amy Jo Johnson
Analysis of:	First Edition		Committee Counsel

SUMMARY:

Senate Bill 223 allows an area mental health, developmental disabilities, and substance abuse board to offer severance benefits, relocation expenses or both to an applicant for the position of area director.

CURRENT LAW:

G.S. 122C-121(a2) prohibits an area mental health, developmental disabilities, and substance abuse board (area board) from offering any benefits to the area director that are not also provided to all permanent employees of the area mental health, development disabilities, and substance abuse program.

BILL ANALYSIS:

Senate Bill 223 would allow an area board to offer severance benefits, relocation expenses, or both when making an offer of employment to a candidate for the area director position.

EFFECTIVE DATE:

This act is effective when it becomes law.

O. Walker Reagan
Director



* S 2 2 3 - S M T K - 1 3 E 1 - V 3 *

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 208
PROPOSED COMMITTEE SUBSTITUTE S208-CSMG-8 [v.10]

3/12/2013 6:13:02 PM

Short Title: Effective Operation of 1915(b)/(c) Waiver.

(Public)

Sponsors:

Referred to:

March 7, 2013

A BILL TO BE ENTITLED
AN ACT TO ENSURE EFFECTIVE STATEWIDE OPERATION OF THE 1915 (B)/(C)
MEDICAID WAIVER.

Whereas, S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, required the Department of Health and Human Services (Department) to restructure the statewide management of the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through the statewide expansion of the 1915(b)/(c) Medicaid Waiver; and

Whereas, a local management entity/managed care organization (LME/MCO) that is awarded a contract to operate the 1915(b)/(c) Medicaid Waiver must maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model; and

Whereas, LME/MCOs are acting as Medicaid vendors and the Department must ensure that they are compliant with the provisions of S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, as well as all applicable federal, State, and contractual requirements; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO" means an LME that has been approved by the Department to operate the 1915(b)/(c) Medicaid Waiver."

SECTION 2. Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under the 1915(b)/(c) Medicaid Waiver.

(a) For LME/MCOs with whom the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for less than three years, the Secretary shall certify every six months that the LME/MCO is in compliance with the requirements of subdivisions (1) through (3) of this subsection. For LME/MCOs with whom the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for at least three years, the Secretary shall annually certify that the LME/MCO is in compliance with the requirements of subdivisions (1) through (3) of this subsection. The Secretary's certification shall be in writing, include the Secretary's signature, and include a clear and unequivocal statement that the Secretary has determined the LME/MCO to be in full compliance with all of the following requirements:

(1) The LME/MCO is financially solvent. The Secretary shall not certify that an LME/MCO is financially solvent if either of the following is true for the LME/MCO:



* S 2 0 8 - C S M G - 8 - V - 1 0 *

- 1 a. Medical expenses, including estimates of incurred but not reported
2 expenses, exceed one hundred percent (100%) of the amount of the
3 LME/MCO's total monthly capitation payment, excluding any
4 administrative load, for any consecutive three-month period, and the
5 amount of unrestricted cash on hand that is available to pay claims on
6 the last date of the consecutive three-month period is less than the
7 average amount of monthly medical expenses, including estimates of
8 incurred but not reported expenses, for the consecutive three-month
9 period.
- 10 b. The amount of cash on hand that is available to pay claims is at any
11 time less than the average amount of monthly medical expenses,
12 including estimates of incurred but not reported expenses, for the
13 most recently completed three-month period.
- 14 (2) The LME/MCO is making timely provider payments. The Secretary shall
15 not certify that an LME/MCO is making timely payments if, for any three
16 consecutive months, the LME/MCO pays less than ninety percent (90%) of
17 clean claims for covered services within the 30-day period following the
18 LME/MCO's receipt of these claims. As used in this subdivision, "clean
19 claims" are claims that can be processed without obtaining additional
20 information from the provider of the services or from a third party. Clean
21 claims do not include claims under review for medical necessity, or claims
22 from a provider that is under investigation by a governmental agency for
23 fraud or abuse.
- 24 (3) The LME/MCO is exchanging billing, payment, and transaction information
25 with the Department and providers in a manner that complies with all
26 applicable federal standards, including but not limited to all of the following.
- 27 a. Standards for information transactions and data elements specified in
28 42 U.S.C. 1302d-2 of the Healthcare Insurance Portability and
29 Accountability Act (HIPAA), as from time to time amended.
- 30 b. Standards for health care claims or equivalent encounter information
31 transaction specified in HIPAA regulations in 45 C.F.R. 162.1102, as
32 from time to time amended.
- 33 c. Implementation specifications for Electronic Data Interchange
34 standards published and maintained by the Accredited Standards
35 Committee (ASC X12) and referenced in HIPAA regulations in 45
36 C.F.R. 162.920.
- 37 (b) If the Secretary is unable to provide an LME/MCO with the certification of
38 compliance required by this section on the date the certification is due because the LME/MCO
39 has failed to comply with any of the requirements specified in subdivisions (1) through (3) of
40 subsection (a) of this section, then the Secretary shall, not later than 30 days after the
41 Secretary's certification of compliance was due for the LME/MCO, assign the LME/MCO's
42 contract to operate the 1915(b)/(c) Medicaid Waiver to a compliant LME/MCO. Upon
43 assigning a contract pursuant to this subsection, the Secretary shall effectuate an orderly
44 transfer of management responsibilities from the noncompliant LME/MCO to a compliant
45 LME/MCO, including the responsibility of paying providers for covered services, in order to
46 ensure the uninterrupted provision of medically necessary services to Medicaid recipients.
- 47 (c) If, in the Secretary's determination, an LME/MCO is in substantial noncompliance
48 with a requirement other than those specified in subdivisions (1) through (3) of subsection (a)
49 of this section, then the Secretary may, not later than 30 days after the Secretary's
50 determination, assign the LME/MCO's contract to operate the 1915(b)/(c) Medicaid Waiver to
51 a compliant LME/MCO. Upon assigning a contract pursuant to this subsection, the Secretary

1 shall effectuate an orderly transfer of management responsibilities from the noncompliant
2 LME/MCO to a compliant LME/MCO, including the responsibility of paying providers for
3 covered services, in order to ensure the uninterrupted provision of medically necessary services
4 to Medicaid recipients.

5 (d) The Secretary shall provide a copy of each written, signed certification of
6 compliance completed in accordance with this section to the Senate Appropriations Committee
7 on Health and Human Services, the House Appropriations Subcommittee on Health and Human
8 Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal
9 Research Division."

10 SECTION 3. By no later than August 1, 2013, the Secretary of Health and Human
11 Services shall complete an initial certification of compliance, in accordance with
12 G.S. 122C-124.2(a), for each LME/MCO that has been approved by the Department to operate
13 the 1915(b)/(c) Medicaid Waiver and provide a copy of the certification to the Senate
14 Appropriations Committee on Health and Human Services, the House Appropriations
15 Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health
16 and Human Services, and the Fiscal Research Division.

17 SECTION 4. Notwithstanding any provision of law to the contrary, all
18 requirements specified in S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, remain
19 in effect until repealed in whole or in part by an act of the General Assembly.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 208

Short Title: Effective Operation of 1915(b)/(c) Waiver. (Public)

Sponsors: Senators Tucker, Barringer (Primary Sponsors); Clark and Hise.

Referred to: Health Care.

March 7, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO ENSURE EFFECTIVE STATEWIDE OPERATION OF THE 1915 (B)/(C)
3 MEDICAID WAIVER.

4 Whereas, S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, required the
5 Department of Health and Human Services (Department) to restructure the statewide
6 management of the delivery of services for individuals with mental illness, intellectual and
7 developmental disabilities, and substance abuse disorders through the statewide expansion of
8 the 1915(b)/(c) Medicaid Waiver; and

9 Whereas, local management entities (LMEs) that are awarded contracts to operate
10 the 1915(b)/(c) Medicaid Waiver must maintain fidelity to the Piedmont Behavioral Health
11 (PBH) demonstration model; and

12 Whereas, these LMEs are acting as Medicaid vendors and the Department must
13 ensure that they are compliant with the provisions of S.L. 2011-264, as amended by Section 13
14 of S.L. 2012-151, as well as all applicable federal, State, and contractual requirements; Now,
15 therefore,

16 The General Assembly of North Carolina enacts:

17 SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

18 "(20c) "Local management entity/managed care organization" or "LME/MCO"
19 means an LME that has been approved by the Department to operate the
20 1915(b)/(c) Medicaid Waiver."

21 SECTION 2. Article 4 of Chapter 122C of the General Statutes is amended by
22 adding a new section to read:

23 "§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral
24 health services under the 1915(b)/(c) Medicaid Waiver.

25 (a) For LME/MCOs with whom the Department has contracted to operate the
26 1915(b)/(c) Medicaid Waiver for less than three years, the Secretary shall provide an
27 unqualified attestation every six months that the LME/MCO is in compliance with (i) the terms
28 of its contract with the Department, (ii) S.L. 2011-264, as amended by Section 13 of S.L.
29 2012-151, and (iii) all other applicable State and federal requirements. For LME/MCOs with
30 whom the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for at least
31 three years, the Secretary shall provide this unqualified attestation of compliance in writing on
32 an annual basis. The Secretary shall specifically address the following requirements in each
33 attestation:

34 (1) Solvency.

35 (2) Timeliness of provider payments.



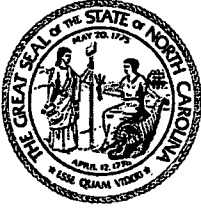
- 1 (3) Compliance with the requirements of S.L. 2011-264, as amended by Section
2 13 of S.L. 2012-151.
- 3 (4) Compliance with the provisions of any contract in effect between the
4 LME/MCO and the Department with respect to management responsibilities
5 for the delivery of services for individuals with mental illness, intellectual or
6 other developmental disabilities, and substance abuse disorders under the
7 1915(b)/(c) Medicaid Waiver.
- 8 (5) The ability to exchange billing, payment, and transaction information with
9 LME/MCOs and providers in a manner that complies with all applicable
10 federal standards, including but not limited to all of the following.
- 11 a. Standards for information transactions and data elements specified in
12 42 U.S.C. 1302d-2 of the Healthcare Insurance Portability and
13 Accountability Act (HIPAA), as from time to time amended.
- 14 b. Standards for health care claims or equivalent encounter information
15 transaction specified in HIPAA regulations in 45 C.F.R. 162.1102, as
16 from time to time amended.
- 17 c. Implementation specifications for Electronic Data Interchange
18 standards published and maintained by the Accredited Standards
19 Committee (ASC X12) and referenced in HIPAA regulations in 45
20 C.F.R. 162.920.

21 (b) If the Secretary is unable to provide an LME/MCO with the unqualified attestation
22 of compliance required by subsection (a) of this section on the date the attestation is due
23 because the LME/MCO is noncompliant, then the Secretary shall assign the LME/MCO's
24 contract to operate the 1915(b)/(c) Medicaid Waiver to another LME/MCO no later than thirty
25 days after the Secretary's unqualified attestation of compliance was due for the LME/MCO.
26 Upon assigning a contract pursuant to this subsection, the Secretary shall effectuate an orderly
27 transfer of management responsibilities from the noncompliant LME/MCO to a compliant
28 LME/MCO, including the responsibility of paying providers for covered services, in order to
29 ensure uninterrupted provision of medically necessary services to Medicaid recipients.

30 (c) The Secretary shall provide a copy of each unqualified attestation of compliance
31 completed in accordance with this section to the Senate Appropriations Committee on Health
32 and Human Services, the House Appropriations Subcommittee on Health and Human Services,
33 the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research
34 Division."

35 **SECTION 3.** By no later than June 30, 2013, the Secretary of Health and Human
36 Services shall complete an initial unqualified attestation of compliance, in accordance with
37 G.S. 122C-124.2(a), for each LME that has been approved by the Department to operate the
38 1915(b)/(c) Medicaid Waiver and provide a copy of the attestation to the Senate Appropriations
39 Committee on Health and Human Services, the House Appropriations Subcommittee on Health
40 and Human Services, the Legislative Oversight Committee on Health and Human Services, and
41 the Fiscal Research Division.

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



SENATE BILL 208: Effective Operation of 1915(b)/(c) Waiver

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Tucker, Barringer
Analysis of: PCS to First Edition
S208-CSMG-8

Date: March 12, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *The Proposed Committee Substitute (PCS) for Senate Bill 208 outlines actions required of the Secretary of the Department of Health and Human Services with regard to Local Management Entities/Managed Care Organizations (LME/MCOs) contracted to operate under the 1915(b)/(c) Medicaid Waiver.*

CURRENT LAW: S.L. 2011-264 (HB 916), as amended by Section 13, S.L. 2012-151, directed the Department of Health and Human Services (DHHS) to proceed with statewide restructuring of the management responsibilities through the expansion of the 1915(b)/(c) Medicaid Waiver for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders. The law as amended specified requirements for DHHS while implementing the restructuring and expansion of services. Below are dates and corresponding requirements.

August 1, 2011: DHHS to select Local Management Entities (LMEs) that had been assessed to meet minimum criteria for Waiver operation.

October 1, 2011: DHHS, with input from others, to submit a strategic plan delineating strategies and agency responsibilities for the achievement of specific objectives and deadlines.

January 1, 2013: For LMEs that had not been approved to operate a 1915(b)/(c) Waiver, DHHS was to require them to merge, or be aligned through an interlocal agreement, with an approved LME. For any LME failing to comply or failing to meet performance requirements of an approved contract, the Department must assign management responsibility for the 1915(b)/(c) Waiver to an LME that is successfully operating the waiver.

Periodic: DHHS required to provide periodic status reports to the General Assembly.

July 1, 2013: Completion date for expansion of the 1915(b)/(c) Waiver.

BILL ANALYSIS: Sections 1 and 2 of the PCS for SB 208 amend Chapter 122C which provides for mental health services.

Section 1 sets out a new definition in G.S. 122C-3, to define "local management entity/managed care organization" or "LME/MCO" as an LME approved by the Department to operate the 1915(b)/(c) Medicaid Waiver.

Section 2 adds a new section, G.S. 122C-124.2, to Article 4, Part 2, of Chapter 122C, requiring certain actions by the Secretary of the Department of Health and Human Services (DHHS) relating to the management of behavioral health services under the 1915(b)/(c) Medicaid Waiver. Actions by the Secretary fall into three broad categories under G.S. 122C-124.2:

- a) the Secretary certifies that each LME/MCO is in compliance with requirements specified in subsection (a);
- b) the Secretary is unable to provide the LME/MCO with certification of compliance with requirements specified in subsection (a); or

O. Walker Reagan
Director



Research Division
(919) 733-2578

Senate PCS 208

Page 2

c) the Secretary determines the LME/MCO is in substantial noncompliance with requirements other than those specified in subsection (a).

G.S. 122C-124.2 Subsections:

Subsection (a) provides that for those LME/MCOs with whom DHHS has contracted to operate the 1915(b)/(c) Medicaid Waiver for less than three years, the DHHS Secretary must certify every six months that the LME/MCO is in compliance with the requirements specified. For those LME/MCOs with whom DHHS has contracted to operate for at least three years, the Secretary shall annually certify compliance with the requirements specified. The Secretary's certification must be in writing, include the Secretary's signature, and include a clear and unequivocal statement that the Secretary had determined the LME/MCO is in full compliance with certain requirements. A summary of the requirements are as follows:

(1) LME/MCO is financially solvent, which means that the medical expenses cannot exceed 100% of the total monthly capitation payment, excluding administrative load, for any three-month period, and the amount of cash on hand to pay claims on the last date of the consecutive three-month period is less than the average amount of monthly medical expenses, including estimates of incurred but not reported expenses. Additionally for the most recently completed three-month period, the amount of cash on hand to pay claims must be more than the average amount of monthly medical expenses, including estimates of incurred but not reported expenses.

(2) LME/MCO is making timely provider payments. An LME/MCO would not be deemed to be making timely provider payments if for any three consecutive months the LME/MCO pays less than 90% of clean claims for covered services within the 30-day period following receipt by the LME/MCO.

(3) LME/MCO is exchanging billing, payment, and transaction information with DHHS and providers in a manner that complies with all federal standards.

Subsection (b) pertains to actions required by the DHHS Secretary when she is unable to certify that an LME/MCO is in compliance with requirements (1)-(3) provided in subsection (a). In the event that the Secretary is unable to certify compliance, no later than 30 days after the Secretary's certification would have been due, the Secretary must assign the LME/MCO's contract to operate the 1915(b)/(c) Medicaid Waiver to a compliant LME/MCO and effectuate an orderly transfer of management responsibilities, including the responsibility of paying providers for services to ensure the uninterrupted provision of medically necessary services.

Subsection (c) pertains to actions required by the Secretary when an LME/MCO is in substantial noncompliance with a requirement other than those provided in subsection (a)(1)-(3). In the event that the Secretary finds substantial noncompliance with requirements other than those in (a)(1)-(3), no later than 30 days after the Secretary's determination, the Secretary must assign the LME/MCO's contract to operate the 1915(b)/(c) Medicaid Waiver to a compliant LME/MCO and effectuate an orderly transfer of management responsibilities, including the responsibility of paying providers for services to ensure the uninterrupted provision of medically necessary services.

Subsection (d) requires the Secretary to provide a copy of each written, signed certification of compliance completed to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

Section 3 of the PCS requires that no later than August 1, 2013, the Secretary must complete an initial certification of compliance, in accordance with G.S. 122C-124.2(a), for each LME/MCO that has been

Senate PCS 208

Page 3

approved by the Department to operate the 1915(b)/(c) Medicaid Waiver. The Secretary is required to provide a copy of the certification to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

Section 4 of the PCS provides that notwithstanding any law to the contrary, the requirements specified in S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, remain in effect until repealed in whole or in part by an act of the General Assembly.

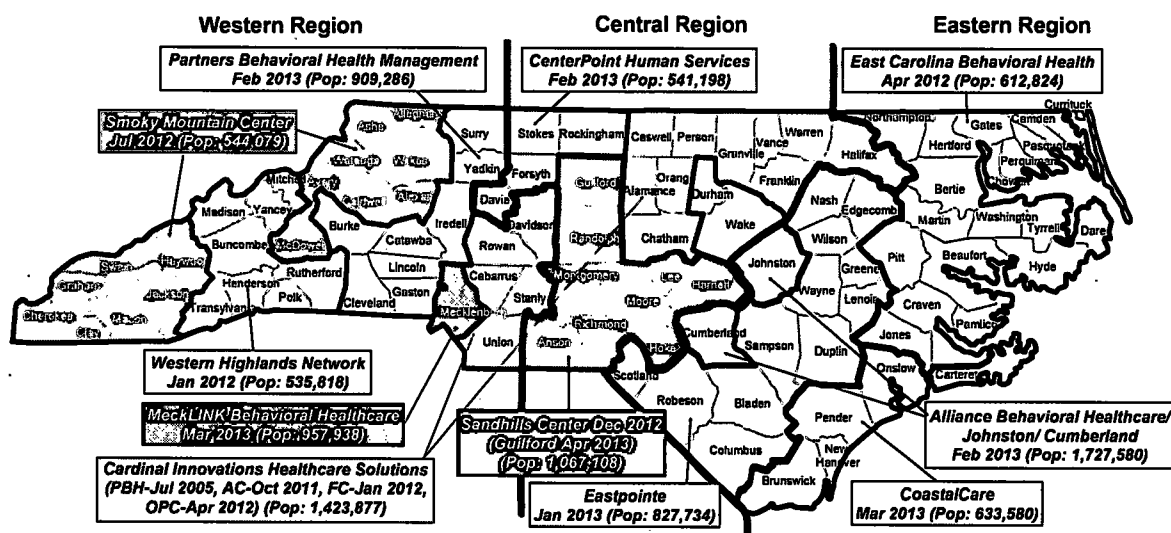
EFFECTIVE DATE: SB 208 would become effective when it becomes law.

BACKGROUND: 1915(b)/(c) Medicaid Waiver refers to two sections of the Social Security Act allowing states to apply for a waiver from Medicaid policy. A 1915(b) waiver would allow a state to provide services through managed care systems or to otherwise limit the choice of providers. A 1915(c) waiver would allow a state to provide services in a home and community setting rather than an institutional setting. States may also elect to concurrently implement two types of waivers. Currently 99 counties in North Carolina operate under a 1915(b)/(c) waiver. Guilford is expected to come online 4/1/13.

According to the Department, Readiness Reviews evaluate whether an LME has the infrastructure necessary to operate as a Managed Care Organization (MCO). They are completed 120 days and 60 days prior to an LME becoming an MCO and additional reviews may be conducted based on the results of the initial review. Annual reviews will occur post transition. Reviews include two tracks: Administrative and Clinical. The administrative track reviews IT, Claims and Finance. The clinical track reviews Customer Services, Quality Management, Provider Network Management, Utilization Management/Care Management and Care Coordination.

The LME/MCO Map below was provided by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

**Local Management Entity - Managed Care Organizations (LME-MCOs)
1915 b/c Medicaid Waiver Implementation Dates and Population**



- For proposed LME-MCOs that have not yet merged, the lead LME name is shown first.
- Dates shown through February 2013 are actual Waiver start dates.
- Dates after February 2013 are the planned Waiver start dates.
- Reflects plans and accomplishments as of February 21, 2013.
- Population is NC OSBM July 2012 population estimates, updated 5/8/12.

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

3/13/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Jeff Shipp	NCTIA
Betsy Vetter	American Heart Assn
Peg O'Connell	March of Dimes
Suzanna Davis	Williams Mullen
Rebecca Tenenbaum	NCACC
PAIGE WORSHAM	NC Center for Public Policy Research
Dan Coughlin	NC Council of Community Devel
Phyllis McHon	Partners Behavioral Health Mgt.
Chuck Stone	SEAR
Adam Sholar	DHHS
Kelly Crook	DHHS - DMA
Jim JARRARD	DHHS - DML/DD/SAS
Steve Mange	DHHS - DMA
Kay Emanuel	School of Government
Sarah Wolfe	MWC LLC
Max Miller	KL6
Colleen Kuchanek	NCCEP

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

3/13/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Andy Chase	KMA
C Nelson	NCHA
Wendy Kelly	Pol'y Group
RETIRED MAYNARD	GM
Maem Gardner	GSE
JOE MAYNARD	GM & ADON
JEFF BARNHART	MWC
JENNIFER ROSEN	Alzheimer's Association
Randi Kymen	Alzheimer's Association
Mary Boley	AARP NC
Susan Harrison	NCSNA
Elise McDowell	Trouman & Sons
Deborah	TRK
Julia Adams	The Arc of NC
JOE LAMBER	NELSON MULLINS
John M	B
Annaliese Dolph	Dolph Law

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

3/13/13
Date

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

[illegible]

Senate Committee on Health Care
Wednesday, March 20, 2013, 11:00 am
544

AGENDA

Welcome and Opening Remarks

Introduction of Pages & Sergeants-at-Arms

Bills:

BILL NO.	SHORT TITLE	SPONSOR
SB 140	Financial Exploitation of Older Adults	Senator Bingham
SB 83	Encourage Volunteer Care in Free Clinics	Senator Bingham

Adjournment

**Senate Committee on Health Care
Wednesday, March 20, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on March 20, 2013 in Room 544 of the Legislative Office Building. Seventeen (17) members were present.

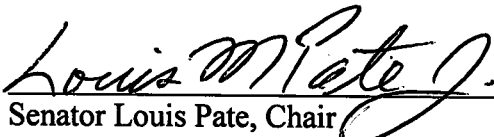
Senator Louis Pate, Chair, presided.

Senator Pate called the meeting to order and welcomed everyone. He then recognized the Sergeants-at-Arms for the meeting: Ed Kesler, Billy Fritscher and Steve Wilson. He also recognized the following Pages assisting with the meeting: Annissa Zak from Fuquay-Varina, Kevin Upadhaya from Durham, Timothy Daye from Henderson, and Richard Perrigo from Roxboro.

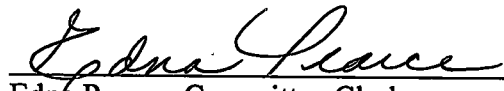
Senator Stan Bingham was asked to explain SB 140 - "Financial Exploitation of Older Adults." After numerous questions, Senator Allran made an amendment to the Proposed Committee Substitute to the original bill resulting in a new PCS. The new PCS received a favorable report with a recommendation that it be referred to the Judiciary I Committee.

Senator Bingham was also recognized to explain SB 83 – a bill to "Encourage Volunteer Care in Free Clinics." The Proposed Committee Substitute received a favorable report with unfavorable to the original bill.

The meeting adjourned at 11:50 a.m.



Senator Louis Pate, Chair
Presiding



Edna Pearce, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
it: Tuesday, March 19, 2013 04:32 PM
to: Sen. Stan Bingham
Cc: Judy Chriscoe (Sen. Stan Bingham)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wednesday, March 20, 2013 at 11:00 AM - CORRECTED #1

Principal Clerk _____
Reading Clerk _____

Corrected #1: AMENDED NOTICE - SB 83

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 20, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 140	Financial Exploitation of Older Adults.	Senator Bingham
SB 83	Encourage Volunteer Care in Free Clinics.	Senator Bingham

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Thursday, March 21, 2013

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

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

SB 140

Financial Exploitation of Older Adults.

Draft Number: S140-PCS35187-SH-1

Sequential Referral: None

Recommended Referral: Judiciary I

Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Stan Bingham will handle SB 140



★ C M R 1 5 2 - V - 2 ★

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, March 20, 2013

Senator Pate,

submits the following with recommendations as to passage:

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

SB 83

Encourage Volunteer Care in Free Clinics.

Draft Number: S83-PCS85112-RF-2

Sequential Referral: None

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Stan Bingham will handle SB 83



* C M R 1 5 1 - V - 2 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 140*
PROPOSED COMMITTEE SUBSTITUTE S140-PCS35187-SH-1

Short Title: Financial Exploitation of Older Adults.

(Public)

Sponsors:

Referred to:

February 28, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO INCREASE THE RECOGNITION, REPORTING, AND PROSECUTION OF
3 THOSE WHO WOULD DEFRAUD OR FINANCIALLY EXPLOIT OLDER ADULTS
4 AND TO CONTINUE THE TASK FORCE ON FRAUD AGAINST OLDER ADULTS,
5 AS RECOMMENDED BY THE TASK FORCE ON FRAUD AGAINST OLDER
6 ADULTS.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. G.S. 14-112.2 reads as rewritten:

9 "§ 14-112.2. Exploitation of an elder-older adult or disabled adult.

10 (a) The following definitions apply in this section:

11 (1) Disabled adult. – A person 18 years of age or older or a lawfully
12 emancipated minor who is present in the State of North Carolina and who is
13 physically or mentally incapacitated as defined in G.S. 108A-101(d).

14 (2) Elder-Older adult. – A person 60 years of age or older who is not able to
15 provide for the social, medical, psychiatric, psychological, financial, or legal
16 services necessary to safeguard the person's rights and resources and to
17 maintain the person's physical and mental well-being-older.

18 (b) It is unlawful for a person: (i) who stands in a position of trust and confidence with
19 an elder-older adult or disabled adult, or (ii) who has a business relationship with an elder-older
20 adult or disabled adult to knowingly, by deception or intimidation, obtain or use, or endeavor to
21 obtain or use, an elder-older adult's or disabled adult's funds, assets, or property with the intent
22 to temporarily or permanently deprive the elder-older adult or disabled adult of the use, benefit,
23 or possession of the funds, assets, or property, or to benefit someone other than the elder-older
24 adult or disabled adult.

25 (c) It is unlawful for a person, who knows or reasonably should know that an elder
26 adult or disabled adult lacks the capacity to consent, person to knowingly, by deception or
27 intimidation, obtain or use, endeavor to obtain or use, or conspire with another to obtain or use
28 an elder-older adult's or disabled adult's funds, assets, or property with the intent to temporarily
29 or permanently deprive the elder-older adult or disabled adult of the use, benefit, or possession
30 of the funds, assets, or property, or benefit someone other than the elder-older adult or disabled
31 adult. This subsection shall not apply to a person acting within the scope of that person's lawful
32 authority as the agent for the elder-older adult or disabled adult.

33 (d) A violation of subsection (b) of this section is punishable as follows:

34 (1) If the funds, assets, or property involved in the exploitation of the elderly
35 person-older adult or disabled adult is valued at one hundred thousand
36 dollars (\$100,000) or more, then the offense is a Class F felony.



* S 1 4 0 - P C S 3 5 1 8 7 - S H - 1 *

- (2) If the funds, assets, or property involved in the exploitation of the ~~elderly person-older adult~~ or disabled adult is valued at twenty thousand dollars (\$20,000) or more but less than one hundred thousand dollars (\$100,000), then the offense is a Class G felony.
- (3) If the funds, assets, or property involved in the exploitation of the ~~elderly person-older adult~~ or disabled adult is valued at less than twenty thousand dollars (\$20,000), then the offense is a Class H felony.
- (e) A violation of subsection (c) of this section is punishable as follows:
- (1) If the funds, assets, or property involved in the exploitation of the ~~elderly person-older adult~~ or disabled adult is valued at one hundred thousand dollars (\$100,000) or more, then the offense is a Class G felony.
- (2) If the funds, assets, or property involved in the exploitation of the ~~elderly person-older adult~~ or disabled adult is valued at twenty thousand dollars (\$20,000) or more but less than one hundred thousand dollars (\$100,000), then the offense is a Class H felony.
- (3) If the funds, assets, or property involved in the exploitation of the ~~elderly person-older adult~~ or disabled adult is valued at less than twenty thousand dollars (\$20,000), then the offense is a Class I felony."

SECTION 2.(a) G.S. 53B-4 is amended by adding a new subdivision to read as follows:

"§ 53B-4. Access to financial records.

Notwithstanding any other provision of law, no government authority may have access to a customer's financial record held by a financial institution unless the financial record is described with reasonable specificity and access is sought pursuant to any of the following:

...

- (13) A written notice of investigation of suspected financial exploitation of an adult delivered to the financial institution by a county department of social services director investigating a credible report of financial exploitation of a disabled adult, pursuant to G.S. 108A-106.1, or by a law enforcement agency investigating possible financial exploitation of an older adult, pursuant to G.S. 108A-116. Delivery of the written notice shall be effected by hand, via certified mail, return receipt requested, or through a designated delivery service authorized pursuant to 26 U.S.C. § 7502(f)(2). The recipient of the written notice shall be the financial institution's local branch vice president, its local branch manager or assistant branch manager, or the agent for service of process listed by the financial institution with the North Carolina Secretary of State."

SECTION 2.(b) G.S. 53B-9(a) reads as rewritten:

"§ 53B-9. Duty of financial institutions; fee; limitation of liability.

(a) Upon receipt of a notice pursuant to G.S. 53B-4(13) or upon service of a subpoena or court order pursuant to G.S. 53B-4(1), (3), (9), or (11) and receipt of certification pursuant to G.S. 53B-5(5), a financial institution shall locate the financial records requested and prepare to make them available to the government authority seeking access to them. Upon receipt of notice that a customer has challenged the notice of investigation, ~~court order~~, or subpoena, the financial institution may suspend its efforts to make the records available until after final disposition of the challenge."

SECTION 3. Article 6 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"§ 108A-106.1. Production of customers' financial records upon request in cases of suspected financial exploitation; immunity; records may not be used against account owner.

1 (a) A financial institution shall promptly provide to the director the financial records of
2 a disabled adult customer if the director or the director's designee has delivered to the financial
3 institution a signed, written notice on department letterhead identifying the disabled adult and
4 specifying all of the following:

5 (1) The director's department is investigating a credible report that the adult is
6 being or has been financially exploited due to his or her disability.

7 (2) The disabled adult's financial records are needed in order to substantiate or
8 evaluate the report.

9 (3) Time is of the essence in order to prevent further exploitation of that adult.

10 (b) All produced copies of the adult's financial records shall be kept confidential by the
11 county department of social services unless required by court rules to be disclosed to a party to
12 a court proceeding, or introduced and admitted into evidence in an open court proceeding.

13 (c) No financial institution or county department of social services, or officer or
14 employee thereof, who provides, seeks, or obtains financial records or any other information in
15 accordance with this section, or provides testimony in any judicial proceeding based upon the
16 contents thereof, shall be held liable in any action if they acted in good faith.

17 (d) No customer shall be subject to indictment, criminal prosecution, criminal
18 punishment, or criminal penalty by reason of or on account of anything disclosed by a financial
19 institution pursuant to this section, nor may any information obtained through such disclosure
20 be used as evidence against the customer in any criminal or civil proceeding. Notwithstanding
21 the foregoing, information obtained may be used against a person who is a joint account owner
22 accused of financial exploitation of a disabled adult joint account holder, but solely for criminal
23 or civil proceedings directly related to the alleged financial exploitation of the disabled adult
24 joint account holder.

25 (e) As used in this section, the terms "customer," "financial exploitation," "financial
26 institution," "financial record," and "promptly" have the same meanings as defined in
27 G.S. 108A-113."

28 **SECTION 4.** Chapter 108A of the General Statutes is amended by adding a new
29 Article to read as follows:

30 "Article 6A.

31 "Protection of Older Adults From Financial Exploitation.

32 "§ 108A-112. Legislative intent and purpose.

33 Determined to fight the growing problem of fraud and financial exploitation targeting older
34 adults in North Carolina, the General Assembly enacts this Article to facilitate the collection of
35 records needed to investigate and prosecute such incidents.

36 "§ 108A-113. Definitions.

37 As used in this Article, the following definitions apply:

38 (1) Customer. – A person who has transacted business with a financial
39 institution or has used the services offered by a financial institution.

40 (2) Financial exploitation. – The illegal or improper use of an older adult's
41 financial resources for another's profit or pecuniary advantage.

42 (3) Financial institution. – A banking corporation, trust company, savings and
43 loan association, credit union, or other entity principally engaged in lending
44 money or receiving or soliciting money on deposit.

45 (4) Financial record. – An original of, a copy of, or information derived from a
46 record held by a financial institution pertaining to a customer's relationship
47 with the financial institution and identified with or identifiable with the
48 customer.

49 (5) Law enforcement agency. – A duly accredited State or local government
50 agency possessing authority to enforce the criminal statutes of North
51 Carolina.

(6) Older adult. – An individual 60 years of age or older.

(7) Promptly. – As soon as practicable, with reasonable allowance to be made for the time required to retrieve older data or records that are not readily or immediately retrievable due to their current storage media.

"§ 108A-114. Financial institutions encouraged to maintain list of contacts in case of financial exploitation.

All financial institutions are encouraged, but not required, to offer to its older adult customers the opportunity to submit, and periodically update, a list of persons that the older adult would like the bank to contact in case of suspected financial exploitation of the older adult.

"§ 108A-115. Duty to report suspected fraud; content of report; immunity for reporting.

(a) Any financial institution, or officer or employee thereof, having reasonable cause to believe that an older adult is the victim or target of financial exploitation shall report such information to both of the following:

(1) Persons on the list provided by the customer under G.S. 108A-114, if such a list has been provided by the customer. The financial institution may choose not to contact persons on the provided list if the bank suspects that those persons are financially exploiting the older adult.

(2) The appropriate local law enforcement agency.

(b) The report may be made orally or in writing. The report shall include the name and address of the older adult, the nature of the suspected financial exploitation, and any other pertinent information.

(c) No financial institution, or officer or employee thereof, who makes a report under this section shall be held liable in any action if they acted in good faith.

"§ 108A-116. Production of customers' financial records upon request in cases of suspected financial exploitation; immunity; records may not be used against account owner.

(a) A financial institution promptly shall provide to the head of a law enforcement agency, or his or her designated agent, the financial records of an older adult customer provided that the head of a law enforcement agency or his or her designated agent provides to the financial institution a signed, written notice of investigation on agency letterhead identifying the older adult customer, providing the agency's investigative file number on the matter, and specifying all of the following:

(1) The law enforcement agency is investigating, pursuant to the law enforcement agency's statutory authority, a credible report that the older adult is being or has been financially exploited.

(2) The older adult's financial records are needed in order to substantiate or evaluate the report.

(3) Time is of the essence in order to prevent further exploitation of that older adult.

(b) All produced copies of the older adult's financial records, as well as any information obtained pursuant to the duty to report found in G.S. 108A-114, shall be kept confidential by the law enforcement agency unless required by court rules to be disclosed to a party to a court proceeding, or introduced and admitted into evidence in an open court proceeding.

(c) No financial institution or law enforcement agency, or officer or employee thereof, who provides, seeks, or obtains financial records or any other information in accordance with this section, or provides testimony in any judicial proceeding based upon the contents thereof, shall be held liable in any action if they acted in good faith.

(d) No customer shall be subject to indictment, criminal prosecution, criminal punishment, or criminal penalty by reason of or on account of anything disclosed by a financial institution pursuant to this section, nor may any information obtained through such disclosure

1 be used as evidence against the customer in any criminal or civil proceeding. Notwithstanding
2 the foregoing, information obtained may be used against a person who is a joint account owner
3 accused of financial exploitation of an older adult joint account holder, but solely for criminal
4 or civil proceedings directly related to the alleged financial exploitation of the older adult joint
5 account holder."

6 **SECTION 5.(a)** Section 1(c) of S.L. 2011-189 reads as rewritten:

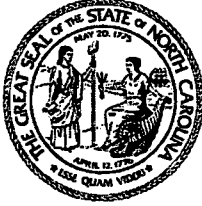
7 "SECTION 1.(c) The Task Force shall make ~~an interim~~ a report to the North Carolina
8 Study Commission on Aging on or before November 1, 2011, and a final report including
9 findings, recommendations, and draft legislation to the Joint Legislative Oversight Committee
10 on Health and Human Services on or before ~~October 1, 2012~~ February 1, 2013. The Task Force
11 shall report to the Joint Legislative Oversight Committee on Health and Human Services prior
12 to the 2014 Regular Session on the efficacy of any of the Task Force's recommendations that
13 are adopted. The Task Force shall terminate on May 1, 2015, or upon the filing of its final
14 report, whichever occurs first."

15 **SECTION 5.(b)** The Consumer Protection Division, Department of Justice, shall
16 add the following to its list of approved associations represented on the Task Force:

17 (1) The North Carolina Credit Union League.

18 (2) An association representing nondepository financial institutions.

19 **SECTION 6.** Sections 1, 2, 3, and 4 of this act become effective on the first day of
20 a month that is six months after this act becomes law. The remainder of this act is effective
21 when it becomes law.



SENATE BILL 140: Financial Exploitation of Older Adults

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: PCS to First Edition
S140-CSSH-1

Date: March 19, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *Senate Bill 140 amends the definition of older adult with regard to financial exploitation; allows local departments of social services and law enforcement agencies access to financial records under certain situations involving suspected financial exploitation against older and disabled adults; exempts entities from liability when acting in good faith to provide, seek, or obtain financial records in situations involving financial exploitation of older and disabled adults; allows financial institutions to maintain lists of contacts for customers should there be a need to report a suspected case of financial exploitation; requires financial institutions to report suspected fraud, but does not hold them liable if they acted in good faith; and extends the Task Force on Fraud Against Older Adults. This bill is a recommendation of the Task Force on Fraud Against Older Adults.*

The Proposed Committee Substitute makes only technical changes.

BILL ANALYSIS:

Section 1 of SB 140 amends G.S. 14-112.2 to change "elder adult" to "older adult" and to broaden the definition as defined in the criminal laws on false pretenses and cheats. With regard to the exploitation of an "older adult", the amended definition keeps the requirement of 60 years of age or older in place, but removes the language requiring diminished capacity. G.S. 14-112.2(c) is amended to make it unlawful for a person to "knowingly, by deception or intimidation," endeavor to, conspire to, or obtain or use an elder or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the individual of the use, benefit, or possession. Under G.S. 14-112.2(e), a violation of subsection (c) is punishable as a Class G felony if it involves funds, assets or property valued at \$100,000; a Class H felony if the funds, assets or property are valued at less than \$100,000 but \$20,000 or more; or a Class I felony if valued at less than \$20,000.

Sections 2 (a) and (b) amend two sections in Chapter 53B. Financial Privacy Act. G.S. 53B-4 defines when a government authority may have access to a customer's financial record held by a financial institution. G.S. 53B-4 is amended to allow government access to a financial record held by a financial institution when it is described with reasonable specificity and access is sought as a result of an investigation of suspected financial exploitation involving an adult. The written notice of suspected financial exploitation involving an adult must be delivered to the financial institution:

- (i) by a county department of social services (DSS) director investigating financial exploitation of a disabled adult pursuant to G.S. 108A-106.1, or
- (ii) by a law enforcement agency investigating possible financial exploitation of an older adult, pursuant to G.S. 108A-116.

The written notice must be delivered by hand, certified mail, return receipt requested, or a delivery service authorized by 26 U.S.C. Section 7502(f)(2). The recipient of the notice must be the financial institution's local branch vice-president, branch manager, assistant branch manager, or the agent for



Senate PCS 140

Page 2

service of process listed with the Secretary of State. Section 2(b) of the bill is a conforming change to 2(a) and requires the financial institution to make the records available. However upon receipt of a notice that a customer has challenged the notice of investigation, the financial institution may suspend efforts to make the records available until final disposition of the challenge.

Section 3 pertains to financial exploitation of disabled adults by adding a section to Article 6 of Chapter 108A, in which departments of social services are involved in the protection of abused, neglected or exploited disabled adults.

Under current law, G.S. 108A-101 defines a "disabled adult" as any person 18 years of age or over or any lawfully emancipated minor who is present in the State and who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy or autism; organic brain damage caused by advanced age or other physical degeneration in connection therewith; or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances.

SB 140 adds G.S. 108A-106.1, which requires a financial institution to provide financial records of a disabled adult customer if the director of the county department of social services, or designee, has delivered to the financial institution a signed, written notice on department letterhead identifying the disabled adult and the existence of certain conditions. The conditions include:

- (1) The director's department is investigating a credible report that the adult is being or has been financially exploited due to his or her disability.
- (2) The disabled adult's financial records are needed to substantiate or evaluate the report.
- (3) Time is of the essence in order to prevent further exploitation of that adult.

G.S. 108A-106.1(b) requires all produced copies of the adult's financial records to be kept confidential by the county department of social services unless required by court rules to be disclosed to a party to a court proceeding, or introduced and admitted into evidence in an open court proceeding.

G.S. 108A-106.1(c) removes liability for that those who provide, seek, or obtain financial records or other information, or provide testimony, as long as they are acting in good faith and in accordance with the provision.

G.S. 108A-106.1(d) prohibits a customer from indictment or criminal prosecution, punishment, or penalty due to anything disclosed by a financial institution pursuant to this statutory section and provides that no information obtained through the disclosure can be used as evidence against the customer in a civil or criminal proceeding. However, this immunity does not apply to criminal or civil proceedings against a joint account owner accused of financial exploitation of the disabled adult joint account holder.

Section 4 adds to Chapter 108A, a new Article 6A entitled, "Protection of Older Adults from Financial Exploitation". G.S. 108A-112 establishes the legislative intent and G.S. 108A-113 sets out definitions for the following terms: Customer, Financial Exploitation, Financial Institution Financial Record, Law Enforcement Agency, Older Adult, and Promptly. The remaining three sections that are being added: encourage financial institutions to maintain a list of contacts, establish a duty for them to report suspected fraud, and require them to provide financial records under certain conditions while removing the liability when providing these records in good faith

G.S. 108A-114 encourages, but does not require, financial institutions to offer older adult customers the opportunity to submit and periodically update, a list of persons the bank should contact in case of suspected financial exploitation of the older adult.

Senate PCS 140

Page 3

G.S. 108A-115 provides that a financial institution, officer or employee with reasonable cause to believe an older adult is a victim or target of financial exploitation must report to: (1) the persons on the list described in G.S. 108A-114, if a list is in place, and if those on the list are not suspects involved in financial exploitation of the older adult; and (2) to the proper law enforcement agency. This report may be oral or in writing but must contain: the name and address of the older adult; the nature of the suspected financial exploitation; and other pertinent information. Subsection (c), similar to G.S. 108A-106.1(b), removes liability for a financial institution, officer, or employee, who reports suspected fraud if they acted in good faith.

G.S. 108A-116(a) contains requirements for older adults that are similar to those in G.S. 108A-106.1(a) for disabled adults, as they relate to requirements for the financial institution to provide the financial records requested if certain conditions are met. Subsection (b) is similar to G.S. 108A-106.1(b) which requires all produced copies of the adult's financial records to be kept confidential. Subsection (c) is similar to G.S. 108A-106.1(c) with regard to removal of liability when providing records in good faith. Subsection (d) is similar to G.S. 108A-106.1(d).

Section 5 amends Section 1(c) of S.L. 2011-189, to extend the Task Force on Fraud Against Older Adults to allow a report to the Joint Legislative Oversight Committee on Health and Human Services prior to the 2014 Regular Session. The Task Force will terminate May 1, 2015, or upon filing its final report, whichever comes first. This section of the bill also requires the NC Credit Union League and an association representing non-depository financial institutions to be added to the Task Force.

EFFECTIVE DATE: Sections 1, 2, 3 and 4 of the bill become effective on the first day of a month that is six months after the act becomes law and the rest of the act is effective when it becomes law.

BACKGROUND: This bill was based on recommendations to the General Assembly from the Task Force on Fraud Against Older Adults which was created by S.L. 2011-189 (SB 449).

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 140*
PROPOSED COMMITTEE SUBSTITUTE S140-CSSH-1 [v.2]

3/19/2013 4:33:18 PM

Short Title: Financial Exploitation of Older Adults.

(Public)

Sponsors:

Referred to:

February 28, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO INCREASE THE RECOGNITION, REPORTING, AND PROSECUTION OF
3 THOSE WHO WOULD DEFRAUD OR FINANCIALLY EXPLOIT OLDER ADULTS,
4 AND TO CONTINUE THE TASK FORCE ON FRAUD AGAINST OLDER ADULTS,
5 AS RECOMMENDED BY THE TASK FORCE ON FRAUD AGAINST OLDER
6 ADULTS.

7 The General Assembly of North Carolina enacts:

8 SECTION 1. G.S. 14-112.2 reads as rewritten:

9 "§ 14-112.2. Exploitation of an ~~elder~~ older adult or disabled adult.

10 (a) The following definitions apply in this section:

11 (1) Disabled adult. – A person 18 years of age or older or a lawfully
12 emancipated minor who is present in the State of North Carolina and who is
13 physically or mentally incapacitated as defined in G.S. 108A-101(d).

14 (2) ~~Elder-Older~~ older adult. – A person 60 years of age or ~~older who is not able to~~
15 ~~provide for the social, medical, psychiatric, psychological, financial, or legal~~
16 ~~services necessary to safeguard the person's rights and resources and to~~
17 ~~maintain the person's physical and mental well-being.~~ older.

18 (b) It is unlawful for a person: (i) who stands in a position of trust and confidence with
19 an elder adult or disabled adult, or (ii) who has a business relationship with an elder adult or
20 disabled adult to knowingly, by deception or intimidation, obtain or use, or endeavor to obtain
21 or use, an elder adult's or disabled adult's funds, assets, or property with the intent to
22 temporarily or permanently deprive the elder adult or disabled adult of the use, benefit, or
23 possession of the funds, assets, or property, or to benefit someone other than the elder adult or
24 disabled adult.

25 (c) It is unlawful for a ~~person, who knows or reasonably should know that an elder~~
26 ~~adult or disabled adult lacks the capacity to consent,~~ person to knowingly, by deception or
27 intimidation, obtain or use, endeavor to obtain or use, or conspire with another to obtain or use
28 an elder adult's or disabled adult's funds, assets, or property with the intent to temporarily or
29 permanently deprive the elder adult or disabled adult of the use, benefit, or possession of the
30 funds, assets, or property, or benefit someone other than the elder adult or disabled adult. This
31 subsection shall not apply to a person acting within the scope of that person's lawful authority
32 as the agent for the elder adult or disabled adult.

33 (d) A violation of subsection (b) of this section is punishable as follows:

34 (1) If the funds, assets, or property involved in the exploitation of the elderly
35 person or disabled adult is valued at one hundred thousand dollars
36 (\$100,000) or more, then the offense is a Class F felony.



* S 1 4 0 - C S S H - 1 - V - 2 *

- (2) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at twenty thousand dollars (\$20,000) or more but less than one hundred thousand dollars (\$100,000), then the offense is a Class G felony.
- (3) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at less than twenty thousand dollars (\$20,000), then the offense is a Class H felony.
- (e) A violation of subsection (c) of this section is punishable as follows:
- (1) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at one hundred thousand dollars (\$100,000) or more, then the offense is a Class G felony.
- (2) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at twenty thousand dollars (\$20,000) or more but less than one hundred thousand dollars (\$100,000), then the offense is a Class H felony.
- (3) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at less than twenty thousand dollars (\$20,000), then the offense is a Class I felony."

SECTION 2.(a) G.S. 53B-4 is amended by adding a new subdivision to read as follows:

"§ 53B-4. Access to financial records.

Notwithstanding any other provision of law, no government authority may have access to a customer's financial record held by a financial institution unless the financial record is described with reasonable specificity and access is sought pursuant to any of the following:

...

- (13) A written notice of investigation of suspected financial exploitation of an adult delivered to the financial institution by a county department of social services director investigating a credible report of financial exploitation of a disabled adult, pursuant to G.S. 108A-106.1, or by a law enforcement agency investigating possible financial exploitation of an older adult, pursuant to G.S. 108A-116. Delivery of the written notice shall be effected by hand, via certified mail, return receipt requested, or through a designated delivery service authorized pursuant to 26 U.S.C. § 7502(f)(2). The recipient of the written notice shall be the financial institution's local branch vice-president, its local branch manager or assistant branch manager, or the agent for service of process listed by the financial institution with the North Carolina Secretary of State."

SECTION 2.(b) G.S. 53B-9(a) reads as rewritten:

"§ 53B-9. Duty of financial institutions; fee; limitation of liability.

(a) Upon receipt of a notice pursuant to G.S. 53B-4(13) or upon service of a subpoena or court order pursuant to G.S. 53B-4(1), (3), (9), or (11) and receipt of certification pursuant to G.S. 53B-5(5), a financial institution shall locate the financial records requested and prepare to make them available to the government authority seeking access to them. Upon receipt of notice that a customer has challenged the notice of investigation, ~~court order~~ order, or subpoena, the financial institution may suspend its efforts to make the records available until after final disposition of the challenge."

SECTION 3. Article 6 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"§ 108A-106.1. Production of customers' financial records upon request in cases of suspected financial exploitation; immunity; records may not be used against account owner.

(a) A financial institution shall promptly provide to the director the financial records of a disabled adult customer if the director or the director's designee has delivered to the financial institution a signed, written notice on department letterhead identifying the disabled adult and specifying all of the following:

(1) The director's department is investigating a credible report that the adult is being or has been financially exploited due to his or her disability.

(2) The disabled adult's financial records are needed in order to substantiate or evaluate the report.

(3) Time is of the essence in order to prevent further exploitation of that adult.

(b) All produced copies of the adult's financial records shall be kept confidential by the county department of social services unless required by court rules to be disclosed to a party to a court proceeding, or introduced and admitted into evidence in an open court proceeding.

(c) No financial institution or county department of social services, or officer or employee thereof, who provides, seeks, or obtains financial records or any other information in accordance with this section, or provides testimony in any judicial proceeding based upon the contents thereof, shall be held liable in any action if they acted in good faith.

(d) No customer shall be subject to indictment, criminal prosecution, criminal punishment, or criminal penalty by reason of or on account of anything disclosed by a financial institution pursuant to this section, nor may any information obtained through such disclosure be used as evidence against the customer in any criminal or civil proceeding. Notwithstanding the foregoing, information obtained may be used against a person who is a joint account owner accused of financial exploitation of a disabled adult joint account holder, but solely for criminal or civil proceedings directly related to the alleged financial exploitation of the disabled adult joint account holder.

(e) As used in this section, the terms "customer," "financial exploitation," "financial institution," "financial record," and "promptly" have the same meanings as defined in G.S. 108A-113."

SECTION 4. Chapter 108A of the General Statutes is amended by adding a new Article to read as follows:

"Article 6A.

"Protection of Older Adults From Financial Exploitation.

"§ 108A-112. Legislative intent and purpose.

Determined to fight the growing problem of fraud and financial exploitation targeting older adults in North Carolina, the General Assembly enacts this Article to facilitate the collection of records needed to investigate and prosecute such incidents.

"§ 108A-113. Definitions.

As used in this Article, the following definitions apply:

(1) Customer. – A person who has transacted business with a financial institution or has used the services offered by a financial institution.

(2) Financial exploitation. – The illegal or improper use of an older adult's financial resources for another's profit or pecuniary advantage.

(3) Financial institution. – A banking corporation, trust company, savings and loan association, credit union, or other entity principally engaged in lending money or receiving or soliciting money on deposit.

(4) Financial record. – An original of, a copy of, or information derived from a record held by a financial institution pertaining to a customer's relationship with the financial institution and identified with or identifiable with the customer.

(6) Law enforcement agency. – A duly accredited state or local government agency possessing authority to enforce the criminal statutes of North Carolina.

(7) Older adult. – An individual 60 years of age or older.

(8) Promptly. – As soon as practicable, with reasonable allowance to be made for the time required to retrieve older data or records that are not readily or immediately retrievable due to their current storage media.

"§ 108A-114. Financial institutions encouraged to maintain list of contacts in case of financial exploitation.

All financial institutions are encouraged, but not required, to offer to its older adult customers the opportunity to submit, and periodically update, a list of persons that the older adult would like the bank to contact in case of suspected financial exploitation of the older adult.

"§ 108A-115. Duty to report suspected fraud; content of report; immunity for reporting.

(a) Any financial institution, or officer or employee thereof, having reasonable cause to believe that an older adult is the victim or target of financial exploitation shall report such information to both of the following:

(1) Persons on the list provided by the customer under G.S. 108A-114, if such a list has been provided by the customer. The financial institution may choose not to contact persons on the provided list if the bank suspects that those persons are financially exploiting the older adult.

(2) The appropriate local law enforcement agency.

(b) The report may be made orally or in writing. The report shall include the name and address of the older adult, the nature of the suspected financial exploitation, and any other pertinent information.

(c) No financial institution, or officer or employee thereof, who makes a report under this section shall be held liable in any action if they acted in good faith.

"§ 108A-116. Production of customers' financial records upon request in cases of suspected financial exploitation; immunity; records may not be used against account owner.

(a) A financial institution promptly shall provide to the head of a law enforcement agency, or his or her designated agent, the financial records of an older adult customer provided that the head of a law enforcement agency or his or her designated agent provides to the financial institution a signed, written notice of investigation on agency letterhead identifying the older adult customer, providing the agency's investigative file number on the matter, and specifying all of the following:

(1) The law enforcement agency is investigating, pursuant to the law enforcement agency's statutory authority, a credible report that the older adult is being or has been financially exploited.

(2) The older adult's financial records are needed in order to substantiate or evaluate the report.

(3) Time is of the essence in order to prevent further exploitation of that older adult.

(b) All produced copies of the older adult's financial records, as well as any information obtained pursuant to the duty to report found in G.S. 108A-114, shall be kept confidential by the law enforcement agency unless required by court rules to be disclosed to a party to a court proceeding, or introduced and admitted into evidence in an open court proceeding.

(c) No financial institution or law enforcement agency, or officer or employee thereof, who provides, seeks, or obtains financial records or any other information in accordance with this section, or provides testimony in any judicial proceeding based upon the contents thereof, shall be held liable in any action if they acted in good faith.

(d) No customer shall be subject to indictment, criminal prosecution, criminal punishment, or criminal penalty by reason of or on account of anything disclosed by a financial institution pursuant to this section, nor may any information obtained through such disclosure

1 be used as evidence against the customer in any criminal or civil proceeding. Notwithstanding
2 the foregoing, information obtained may be used against a person who is a joint account owner
3 accused of financial exploitation of an older adult joint account holder, but solely for criminal
4 or civil proceedings directly related to the alleged financial exploitation of the older adult joint
5 account holder."

6 **SECTION 5.(a)** Section 1(c) of S.L. 2011-189 reads as rewritten:

7 **"SECTION 1.(c)** The Task Force shall make ~~an interim~~ a report to the North Carolina
8 Study Commission on Aging on or before November 1, 2011, and a ~~final~~ report including
9 findings, recommendations, and draft legislation to the Joint Legislative Oversight Committee
10 on Health and Human Services on or before ~~October 1, 2012~~ February 1, 2013. The Task
11 Force shall report to the Joint Legislative Oversight Committee on Health and Human Services
12 prior to the 2014 Regular Session on the efficacy of any of the Task Force's recommendations
13 that are adopted. The Task Force shall terminate on May 1, 2015, or upon the filing of its final
14 report, whichever occurs first."

15 **SECTION 5.(b)** The Consumer Protection Division, Department of Justice, shall
16 add the following to its list of approved associations represented on the Task Force:

17 (1) The North Carolina Credit Union League.

18 (2) An association representing non-depository financial institutions.

19 **SECTION 6.** Sections 1, 2, 3, and 4 of this act become effective on the first day of
20 a month that is six months after this act becomes law. The remainder of this act is effective
21 when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 140*

Short Title: Financial Exploitation of Older Adults.

(Public)

Sponsors: Senators Bingham (Primary Sponsor); Apodaca, Barefoot, Barringer, Brock, Clark, D. Davis, Hise, Hunt, Jackson, Jenkins, McLaurin, Newton, Pate, Rabin, and Randleman.

Referred to: Health Care.

February 28, 2013

A BILL TO BE ENTITLED
AN ACT TO INCREASE THE RECOGNITION, REPORTING, AND PROSECUTION OF
THOSE WHO WOULD DEFRAUD OR FINANCIALLY EXPLOIT OLDER ADULTS,
AND TO CONTINUE THE TASK FORCE ON FRAUD AGAINST OLDER ADULTS,
AS RECOMMENDED BY THE TASK FORCE ON FRAUD AGAINST OLDER
ADULTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-112.2 reads as rewritten:

"§ 14-112.2. **Exploitation of an elder adult or disabled adult.**

(a) The following definitions apply in this section:

(1) Disabled adult. – A person 18 years of age or older or a lawfully emancipated minor who is present in the State of North Carolina and who is physically or mentally incapacitated as defined in G.S. 108A-101(d).

(2) Elder adult. – A person 60 years of age or older who is not able to provide for the social, medical, psychiatric, psychological, financial, or legal services necessary to safeguard the person's rights and resources and to maintain the person's physical and mental well-being. ~~older.~~

(b) It is unlawful for a person: (i) who stands in a position of trust and confidence with an elder adult or disabled adult, or (ii) who has a business relationship with an elder adult or disabled adult to knowingly, by deception or intimidation, obtain or use, or endeavor to obtain or use, an elder adult's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elder adult or disabled adult of the use, benefit, or possession of the funds, assets, or property, or to benefit someone other than the elder adult or disabled adult.

(c) It is unlawful for a ~~person, who knows or reasonably should know that an elder adult or disabled adult lacks the capacity to consent,~~ person to knowingly, by deception or intimidation, obtain or use, endeavor to obtain or use, or conspire with another to obtain or use an elder adult's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elder adult or disabled adult of the use, benefit, or possession of the funds, assets, or property, or benefit someone other than the elder adult or disabled adult. This subsection shall not apply to a person acting within the scope of that person's lawful authority as the agent for the elder adult or disabled adult.

(d) A violation of subsection (b) of this section is punishable as follows:



* S 1 4 0 - V - 1 *

- (1) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at one hundred thousand dollars (\$100,000) or more, then the offense is a Class F felony.
 - (2) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at twenty thousand dollars (\$20,000) or more but less than one hundred thousand dollars (\$100,000), then the offense is a Class G felony.
 - (3) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at less than twenty thousand dollars (\$20,000), then the offense is a Class H felony.
- (e) A violation of subsection (c) of this section is punishable as follows:
- (1) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at one hundred thousand dollars (\$100,000) or more, then the offense is a Class G felony.
 - (2) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at twenty thousand dollars (\$20,000) or more but less than one hundred thousand dollars (\$100,000), then the offense is a Class H felony.
 - (3) If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at less than twenty thousand dollars (\$20,000), then the offense is a Class I felony."

SECTION 2.(a) G.S. 53B-4 is amended by adding a new subdivision to read as follows:

"§ 53B-4. Access to financial records.

Notwithstanding any other provision of law, no government authority may have access to a customer's financial record held by a financial institution unless the financial record is described with reasonable specificity and access is sought pursuant to any of the following:

- ...
- (13) A written notice of investigation of suspected financial exploitation of an adult delivered to the financial institution by a county department of social services director investigating a credible report of financial exploitation of a disabled adult, pursuant to G.S. 108A-106.1, or by a law enforcement agency investigating possible financial exploitation of an older adult, pursuant to G.S. 108A-116. Delivery of the written notice shall be effected by hand, via certified mail, return receipt requested, or through a designated delivery service authorized pursuant to 26 U.S.C. § 7502(f)(2). The recipient of the written notice shall be the financial institution's local branch vice-president, its local branch manager or assistant branch manager, or the agent for service of process listed by the financial institution with the North Carolina Secretary of State."

SECTION 2.(b) G.S. 53B-9(a) reads as rewritten:

"§ 53B-9. Duty of financial institutions; fee; limitation of liability.

(a) Upon receipt of a notice pursuant to G.S. 53B-4(13) or upon service of a subpoena or court order pursuant to G.S. 53B-4(1), (3), (9), or (11) and receipt of certification pursuant to G.S. 53B-5(5), a financial institution shall locate the financial records requested and prepare to make them available to the government authority seeking access to them. Upon receipt of notice that a customer has challenged the notice of investigation, ~~court order~~ order, or subpoena, the financial institution may suspend its efforts to make the records available until after final disposition of the challenge."

SECTION 3. Article 6 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"§ 108A-106.1. Production of customers' financial records upon request in cases of suspected financial exploitation; immunity; records may not be used against account owner.

(a) A financial institution shall promptly provide to the director the financial records of a disabled adult customer or depositor if the director or the director's designee has delivered to the financial institution a signed, written notice on department letterhead identifying the disabled adult and specifying all of the following:

- (1) The director's department is investigating a credible report that the adult is being or has been financially exploited due to his or her disability.
- (2) The disabled adult's financial records are needed in order to substantiate or evaluate the report.
- (3) Time is of the essence in order to prevent further exploitation of that adult.
- (4) All produced copies of the adult's financial records shall be kept confidential by the county department of social services unless required by court rules to be disclosed to a party to a court proceeding, or introduced and admitted into evidence in an open court proceeding.

(b) No financial institution or law enforcement agency, or officer or employee thereof, who provides, seeks, or obtains financial records or any other information in accordance with this section, or provides testimony in any judicial proceeding based upon the contents thereof, shall be held liable in any action if they acted in good faith.

(c) No customer shall be subject to indictment, criminal prosecution, criminal punishment, or criminal penalty by reason of or on account of anything disclosed by a financial institution pursuant to this section, nor may any information obtained through such disclosure be used as evidence against the customer in any criminal or civil proceeding. Notwithstanding the foregoing, information obtained may be used against a person who is a joint account owner accused of financial exploitation of an older adult joint account holder, but solely for criminal or civil proceedings directly related to the alleged financial exploitation of the older adult joint account holder.

(d) As used in this section, the terms "customer," "financial exploitation," "financial institution," "financial record," and "promptly" have the same meanings as defined in G.S. 108A-113."

SECTION 4. Chapter 108A of the General Statutes is amended by adding a new Article to read as follows:

"Article 6A.

"Protection of Older Adults From Financial Exploitation.

"§ 108A-112. Legislative intent and purpose.

Determined to fight the growing problem of fraud and financial exploitation targeting older adults in North Carolina, the General Assembly enacts this Article to facilitate the collection of records needed to investigate and prosecute such incidents.

"§ 108A-113. Definitions.

As used in this Article, the following definitions apply:

- (1) Customer. – A person who has transacted business with a financial institution or has used the services offered by a financial institution.
- (2) Financial exploitation. – The illegal or improper use of an older adult's financial resources for another's profit or pecuniary advantage.
- (3) Financial institution. – A banking corporation, trust company, savings and loan association, credit union, or other entity principally engaged in lending money or receiving or soliciting money on deposit.
- (4) Financial record. – An original of, a copy of, or information derived from a record held by a financial institution pertaining to a customer's relationship

with the financial institution and identified with or identifiable with the customer.

(6) Law enforcement agency. – A duly accredited state or local government agency possessing authority to enforce the criminal statutes of North Carolina.

(7) Older adult. – An individual 60 years of age or older.

(8) Promptly. – As soon as practicable, with reasonable allowance to be made for the time required to retrieve older data or records that are not readily or immediately retrievable due to their current storage media.

"§ 108A-114. Financial institutions encouraged to maintain list of contacts in case of financial exploitation.

All financial institutions are encouraged, but not required, to offer to its older adult customers the opportunity to submit, and periodically update, a list of persons that the older adult would like the bank to contact in case of suspected financial exploitation of the older adult.

"§ 108A-115. Duty to report suspected fraud; content of report; immunity for reporting.

(a) Any financial institution, or officer or employee thereof, having reasonable cause to believe that an older adult is the victim or target of financial exploitation shall report such information to both of the following:

(1) Persons on the list provided by the customer under G.S. 108A-114, if such a list has been provided by the customer. The financial institution may choose not to contact persons on the provided list if the bank suspects that those persons are financially exploiting the older adult.

(2) The appropriate local law enforcement agency.

(b) The report may be made orally or in writing. The report shall include the name and address of the older adult, the nature of the suspected financial exploitation, and any other pertinent information.

(c) No financial institution, or officer or employee thereof, who makes a report under this section shall be held liable in any action if they acted in good faith.

"§ 108A-116. Production of customers' financial records upon request in cases of suspected financial exploitation; immunity; records may not be used against account owner.

(a) A financial institution promptly shall provide to the head of a law enforcement agency, or his or her designated agent, the financial records of an older adult customer or depositor, provided that the head of a law enforcement agency or his or her designated agent provides to the financial institution a signed, written notice of investigation on agency letterhead identifying the older adult customer, providing the agency's investigative file number on the matter, and specifying all of the following:

(1) The law enforcement agency is investigating, pursuant to the law enforcement agency's statutory authority, a credible report that the older adult is being or has been financially exploited.

(2) The older adult's financial records are needed in order to substantiate or evaluate the report.

(3) Time is of the essence in order to prevent further exploitation of that older adult.

(4) All produced copies of the older adult's financial records, as well as any information obtained pursuant to the duty to report found in G.S. 108A-114, shall be kept confidential by the law enforcement agency unless required by court rules to be disclosed to a party to a court proceeding, or introduced and admitted into evidence in an open court proceeding.

1 (b) No financial institution or law enforcement agency, or officer or employee thereof,
2 who provides, seeks, or obtains financial records or any other information in accordance with
3 this section, or provides testimony in any judicial proceeding based upon the contents thereof,
4 shall be held liable in any action if they acted in good faith.

5 (c) No customer shall be subject to indictment, criminal prosecution, criminal
6 punishment, or criminal penalty by reason of or on account of anything disclosed by a financial
7 institution pursuant to this section, nor may any information obtained through such disclosure
8 be used as evidence against the customer in any criminal or civil proceeding. Notwithstanding
9 the foregoing, information obtained may be used against a person who is a joint account owner
10 accused of financial exploitation of an older adult joint account holder, but solely for criminal
11 or civil proceedings directly related to the alleged financial exploitation of the older adult joint
12 account holder."

13 **SECTION 5.(a)** Section 1(c) of S.L. 2011-189 reads as rewritten:

14 **"SECTION 1.(c)** The Task Force shall make ~~an interim~~ a report to the North Carolina
15 Study Commission on Aging on or before November 1, 2011, and a ~~final~~ report including
16 findings, recommendations, and draft legislation to the Joint Legislative Oversight Committee
17 on Health and Human Services on or before ~~October 1, 2012~~ February 1, 2013. The Task
18 Force shall report to the Joint Legislative Oversight Committee on Health and Human Services
19 prior to the 2014 Regular Session on the efficacy of any of the Task Force's recommendations
20 that are adopted. The Task Force shall terminate on May 1, 2015, or upon the filing of its final
21 report, whichever occurs first."

22 **SECTION 5.(b)** The Consumer Protection Division, Department of Justice, shall
23 add the following to its list of approved associations represented on the Task Force:

24 (1) The North Carolina Credit Union League.

25 (2) An association representing non-depository financial institutions.

26 **SECTION 6.** Sections 1, 2, 3, and 4 of this act become effective on the first day of
27 a month that is six months after this act becomes law. The remainder of this act is effective
28 when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 83

Short Title: Encourage Volunteer Care in Free Clinics.

(Public)

Sponsors: Senator Bingham (Primary Sponsor).

Referred to: Health Care.

February 14, 2013

A BILL TO BE ENTITLED
AN ACT TO ENCOURAGE VOLUNTEER HEALTH CARE IN FREE CLINICS BY
LIMITING THE LIABILITY OF HEALTH CARE PROVIDERS IF THE FREE CLINIC
POSTS A NOTICE OF LIMITED LIABILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-21.16 reads as rewritten:

"§ 90-21.16. Volunteer health care professionals; liability limitation.

(a) This section applies as follows:

- (1) Any volunteer medical or health care provider at a facility of a local health department or at a nonprofit community health center,
- (2) Any volunteer medical or health care provider rendering services to a patient referred by a local health department as defined in G.S. 130A-2(5), nonprofit community health center, or nonprofit community health referral service at the provider's place of employment,
- (3) Any volunteer medical or health care provider serving as medical director of an emergency medical services (EMS) agency, or
- (4) Repealed by Session Laws 2011-355, s. 7, effective June 27, 2011.
- (5) Any volunteer medical or health care provider licensed or certified in this State who provides services within the scope of the provider's license or certification at a free clinic facility, who receives no compensation for medical services or other related services rendered at the facility, center, agency, or clinic, or who neither charges nor receives a fee for medical services rendered to the patient referred by a local health department, nonprofit community health center, or nonprofit community health referral service at the provider's place of employment shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the rendering of the services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the services. The free clinic, local health department facility, nonprofit community health center, nonprofit community health referral service, or agency shall use due care in the selection of volunteer medical or health care providers, and this subsection shall not excuse the free clinic, health department facility, community health center, or agency for the failure of the volunteer medical or health care provider to use ordinary care in the provision of medical services to its patients.



(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his or her business or profession. Services provided by a medical or health care provider who receives no compensation for his or her services and who voluntarily renders such services at the provider's place of employment, facilities of free clinics, local health departments as defined in G.S. 130A-2, nonprofit community health centers, or as a volunteer medical director of an emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary course of the volunteer medical or health care provider's business or profession.

(c) As used in this section, a "free clinic" is a nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing health care services without charge or for a minimum fee to cover administrative costs and that ~~maintains liability insurance covering the acts and omissions of the free clinic and any liability pursuant to subsection (a) of this section.~~ posts in a clear and conspicuous manner the following notice in the premises where the provision of health care services is occurring:

"NOTICE

Under North Carolina law, there is no liability for damages for injuries or death alleged to have occurred by reason of an act or omission in the health care provider's voluntary provision of health care services, unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the health care provider."

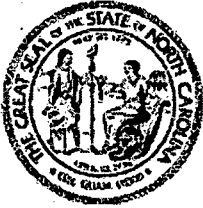
(d) A nonprofit community health referral service that refers low-income patients to physicians for free services is not liable for the acts or omissions of the physician in rendering service to that patient if the nonprofit community health referral service maintains liability insurance covering the acts and omissions of the nonprofit health referral service and any liability pursuant to subsection (a) of this section.

(e) As used in this section, a "nonprofit community health referral service" is a nonprofit, 501(c)(3) tax-exempt organization organized to provide for no charge the referral of low-income, uninsured patients to volunteer health care providers who provide health care services without charge to patients."

SECTION 2. G.S. 90-21.102(2) reads as rewritten:

"(2) Free clinic. — A nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing health care services without charge or for a minimum fee to cover administrative costs and that ~~maintains liability insurance covering the acts and omissions of the free clinic and any liability posts, pursuant to G.S. 90-21.16(a).~~ G.S. 90-21.16(c), a notice of limited liability."

SECTION 3. This act becomes effective October 1, 2013.



SENATE BILL 83: Encourage Volunteer Care in Free Clinics

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Bingham
Analysis of: PCS to First Edition
S83-CSRF-2

Date: March 15, 2013
Prepared by: Barbara Riley
Committee Counsel

SUMMARY: Under G.S. 90-21.16, a "free clinic" is defined as a nonprofit 501(c)(3) organization organized for the purpose of providing free health care services and that maintains liability insurance covering the acts and omissions of the clinic and any liability pursuant to G.S. 90-21.16(a). A medical or health services provider has qualified immunity for services provided within the scope of his or her license at a free clinic. Senate Bill 83 amends the definition of "free clinic" in G.S. 90-21.16(c) by removing the qualification that the clinic maintain liability insurance. The bill also provides that in order for a volunteer medical or health service provider to receive the protection from liability provided under G.S. 90-21.16(a), the free clinic must provide a notice to the patient for the patient to keep, of the limited liability of volunteer medical or health services providers prior to the delivery of health care services.

The proposed committee substitute provides for the notice to be given directly to the patient or the person authorized to consent to the patient's treatment. The original bill simply required the free clinic to post the notice in a conspicuous manner.

CURRENT LAW: G.S. 90-21.16 limits the liability of volunteer medical and health care providers who provide services within the scope of their license at a free clinic (and other covered facilities), and who receive no compensation for their services. Such volunteers are not liable for damages for injuries or death alleged to have occurred by acts or omissions in rendering services, unless such injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer.

A free clinic (and other covered facilities) must use due care in the selection of volunteer medical and health care providers. They remain liable for the failure of a volunteer medical or health services provider to use ordinary care in the provision of medical services to its patients. G.S. 90-21.16(a).

A "free clinic" is defined as a nonprofit 501(c)(3) organization organized for the purpose of providing health care services for free or for a minimum charge to cover administrative costs and that maintains liability insurance covering the acts and omissions of the clinic and any liability pursuant to G.S. 90-21.16(a).

BILL ANALYSIS: Section 1 amends G.S. 90-21.16(c) by removing the qualification in the definition of "free clinic" that such clinics maintain liability covering the acts and omissions of the clinic and any liability pursuant to G.S. 90-21.16(a). Section 1 also adds a new subsection (c1) to the statute providing that in order for a volunteer medical or health services provider to receive the protection from liability provided under G.S. 90-21.16, the free clinic must provide a notice to the patient, or person authorized to consent to treatment, for him or her to keep, prior to treatment as follows:

"NOTICE

O. Walker Reagan
Director



Research Division
(919) 733-2578

Senate PCS 83

Page 2

Under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by of an act or omission in the medical or health care provider's voluntary provision of health care services, unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer medical or health care provider."

Section 2 of the bill amends the definition of free clinic in G.S. 90-21-102(2) to conform to the changes made in Section 1.

EFFECTIVE DATE: The act becomes effective October 1, 2013 and applies to claims that arise on or after that date.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

D

**SENATE BILL 83
PROPOSED COMMITTEE SUBSTITUTE S83-CSRF-2 [v.6]**

3/19/2013 6:58:27 PM

Short Title: Encourage Volunteer Care in Free Clinics.

(Public)

Sponsors:

Referred to:

February 14, 2013

A BILL TO BE ENTITLED
AN ACT TO ENCOURAGE VOLUNTEER HEALTH CARE IN FREE CLINICS BY
LIMITING THE LIABILITY OF MEDICAL AND HEALTH CARE PROVIDERS IF
THE FREE CLINIC PROVIDES PATIENTS WITH NOTICE OF LIMITED LIABILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-21.16 reads as rewritten:

"§ 90-21.16. Volunteer health care professionals; liability limitation.

(a) This section applies as follows:

- (1) Any volunteer medical or health care provider at a facility of a local health department or at a nonprofit community health center,
- (2) Any volunteer medical or health care provider rendering services to a patient referred by a local health department as defined in G.S. 130A-2(5), nonprofit community health center, or nonprofit community health referral service at the provider's place of employment,
- (3) Any volunteer medical or health care provider serving as medical director of an emergency medical services (EMS) agency, or
- (4) Repealed by Session Laws 2011-355, s. 7, effective June 27, 2011.
- (5) Any volunteer medical or health care provider licensed or certified in this State who provides services within the scope of the provider's license or certification at a free clinic facility, who receives no compensation for medical services or other related services rendered at the facility, center, agency, or clinic, or who neither charges nor receives a fee for medical services rendered to the patient referred by a local health department, nonprofit community health center, or nonprofit community health referral service at the provider's place of employment shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the rendering of the services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the person rendering the services. The free clinic, local health department facility, nonprofit community health center, nonprofit community health referral service, or agency shall use due care in the selection of volunteer medical or health care providers, and this subsection shall not excuse the free clinic, health department facility, community health center, or agency for the failure of the volunteer medical or health care provider to use ordinary care in the provision of medical services to its patients.



(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his or her business or profession. Services provided by a medical or health care provider who receives no compensation for his or her services and who voluntarily renders such services at the provider's place of employment, facilities of free clinics, local health departments as defined in G.S. 130A-2, nonprofit community health centers, or as a volunteer medical director of an emergency medical services (EMS) agency, are deemed not to be in the normal and ordinary course of the volunteer medical or health care provider's business or profession.

(c) As used in this section, a "free clinic" is a nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing health care services without charge or for a minimum fee to cover administrative ~~costs~~ costs, ~~and that maintains liability insurance covering the acts and omissions of the free clinic and any liability pursuant to subsection (a) of this section.~~

(c1) For a volunteer medical or health care provider who provides services at a free clinic to receive the protection from liability provided in this section, the free clinic shall provide the following notice to the patient, or person authorized to give consent for treatment, for the patient's retention, prior to the delivery of health care services:

"NOTICE

Under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the medical or health care provider's voluntary provision of health care services, unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer medical or health care provider."

(d) A nonprofit community health referral service that refers low-income patients to physicians for free services is not liable for the acts or omissions of the physician in rendering service to that patient if the nonprofit community health referral service maintains liability insurance covering the acts and omissions of the nonprofit health referral service and any liability pursuant to subsection (a) of this section.

(e) As used in this section, a "nonprofit community health referral service" is a nonprofit, 501(c)(3) tax-exempt organization organized to provide for no charge the referral of low-income, uninsured patients to volunteer health care providers who provide health care services without charge to patients."

SECTION 2. G.S. 90-21.102(2) reads as rewritten:

"(2) Free clinic. — A nonprofit, 501(c)(3) tax-exempt organization organized for the purpose of providing health care services without charge or for a minimum fee to cover administrative ~~costs~~ costs, ~~and that maintains liability insurance covering the acts and omissions of the free clinic and any liability pursuant to G.S. 90-21.16(a).~~"

SECTION 3. This act becomes effective October 1, 2013, and applies to claims that arise on or after that date.

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

3/20/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Ellen Roeder	NCPTA
Sarah Wolf	MWCLLC
Jennifer Renninger	NCSU MSW program
Samirah Furbee	NCSU-MSW
CANCE. Sovrell	NCSU-MSW
T. Ben Douglas	Senior Tax Dept Legislature
Richard C Thompson	Senior Tax Dept Legislature
Nancy Warren	NC Aging + Adult Services
CARLA A. FAGAN	METHODIST UNIVERSITY 5400 RAMSLEY ST., T-332 FAYETTEVILLE, NC 28311
Annaliese Polson	Methodist Law
Nicholas Iannitis	NCSU - School of Social Work
Teri Anderson	LATA
Corey Miller	NCSU - MSW
Lindsey Lum	NCSU - MSW
Happiness Onigbo	Meredith College Undergraduate
Kayla Thomas	NCSU - MSW
Louvenia Hochlear	Fayetteville State Univ. MSW

[illegible]

VISITOR REGISTRATION SHEET

Senate Committee on Health Care
(Committee Name)

3/20/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Caroline Farmer	NC DOJ
Erica Nelson	NCHA
Ashley Emmons	NMSS
Chris Aguer	DOJ
Kyle Hall	NCGA
Patricia Limer	PRF
AISANDER DUDA	NCCPPR
Ron Cole	
PAIGE WORSHAM	NC Center for Public Policy Research
Amanda Morris	Social Work lobby day
Elizabeth Ritz	SOCIAL WORK lobby day
Shienacey Pair	Social Worker / lobby day
Amanda Carrington	
RICK SHIPMAN	NCPTA
DANIEL VAN LIGRE	VIDANT-HEALTH
Tracy Taylor	UNC-CH Physical Therapy Student, DPT 2014
Britt Tatum	UNC-CH Physical Therapy Student

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

3/20/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Delane Frutiger Clerk	UNC-CH
Dirk Colton	~~add~~
Brandon Lindquist	UNC-CH
George Smith	Nexsen Pract
Adam Sholan	DHHS
Michelle O'Neill	UNC-CH
Leigh Rolandelli	UNC-CH
Angela Lauten	UNC-CH
Lauren Suggs	UNC-CH Physical Therapy
Kimberly Dale	UNC-CH Physical Therapy
Olson Maultsby	UNCW SOCIAL WORK
Hta Nguyen	NCCOB
Nathan Batts	NCBA
Sarah Harner	Appalachian State MSW
Alisha Little	Appalachian State MSW
Shannon Saville	ASU MSW
Kaitlin Mullins	Appalachian State MSW

VISITOR REGISTRATION SHEET

Senate Committee on Health Care
(Committee Name)

3/20/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Bettie McKemie	App State - MSW dept.
Jared Huskorn	NCSU - Dept. of Social Work
Suzanne Martin	NCSU Dept. of Social Work
Hayden Dawes	NCSU - Dept of Social Work
Anna Erb	NCSU - dept of social work.
Merissa Jones	NCSU - dept of social work
Cathy Richmond	UNC School of SW MSW student
Ritsy Vetter	American Heart Assn
Sisanna Davis	Williams Mullen
Philip Searcy	NCSU - MSW
Ebony Russell	NCSU - MSW
Pashyon Blake	NCSU - MSW
Jon Carr	NC Assoc Fam Clin
Jason Barden	
Jason Fishkin	Sen. Stein
Lauven Mahaly	NORCUL
Brenda Williams	NC Dept. of State Treasurer

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

3/20/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Barbara Zelter	NCSU, Social Work, Raleigh
Leslie Cloninger	NCSU, Social Work, Raleigh
Lindsay A. Patterson	NCSU Social Work, Raleigh
MARVELEN HAWTHORNE	STHL DARE COUNTY
Kaye White	Sr. Trade Head Delegate - Darr Co.
Mary Beth	AARP - N.C.
Chip Kellian	Nelson Mullins
JEAN MCNEIL	NCPTA
Kayla Walter	PTA Student MCC
Ann Rose	Martin Community, PTA Student
Dawn Hardison	MCC PTA Student
Kay Emanuel	School of Government
Bonita Joyce	UNC-SSW
Stephanie Bias	NC Dept of Insurance
David M. Kirkman	NC Atty Gen.
Dennis W. Streets	NC Div. of Aging & Adult Services
Melane Rao	NC Center for Public Policy

Research

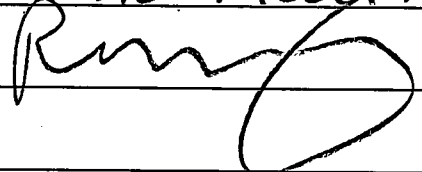
09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care
(Committee Name)

3/20/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Brandon Hall	UNC physical therapy
Liz Waddell	UNC PT / NCPTA
Angel Alford	Nash CC PTA
Andrea Mills	Nash Community College - Rocky Mt, NC
Kathleen Klinger	Nash Community College PTA student
Jason West	Nash Community College PTA student
Josh Southerland	Nash Community College PTA student
Connie Williams	Nash Community College PTA student
Chris Medlin	Nash Community College PTA student
	

[illegible]

**Senate Committee on Health Care
Wednesday, March 27, 2013, 11:00 AM
544 Legislative Office Building**

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 208	Effective Operation of 1915(b)/(c) Waiver.	Senator Tucker Senator Barringer

Adjournment

**Senate Committee on Health Care
Wednesday, March 27, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

Senator Ralph Hise, Chair, presided.

The Senate Committee on Health Care met at 11:00 AM on March 27, 2013, in Room 544 of the Legislative Office Building. Fourteen members of the committee were present.

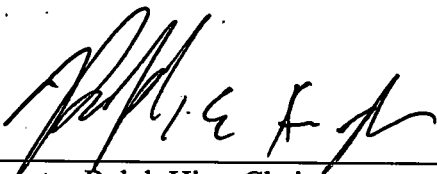
Senator Hise called the meeting to order by welcoming everyone and recognizing the Pages—Jacqlyn Grilli of Union County, Regan Booth of Buncombe County, Maya Finoh of Durham County, Timothy Jordan of Forsyth County, and Rebecca Chisolm of Onslow County—and the Sergeants-at-Arms—Steve Wilson, Ed Kesler, Canton Lewis, and Billy Fritscher.

Senator Tucker was recognized to present Senate Bill 208 – Effective Operation of 1915(b)/(c) Waiver. Senator Randleman moved for adoption of the PCS. The motion carried unanimously.

Senator Tucker explained the PCS and took questions and comments from committee members regarding the PCS.

Senator Randleman made a motion for a favorable report to the PCS, unfavorable to the original bill. The motion carried unanimously.

The meeting adjourned at 11:35 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

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 27, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 208	Effective Operation of 1915(b)/(c) Waiver.	Senator Tucker Senator Barringer

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Thursday, March 28, 2013

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

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

SB 208

Effective Operation of 1915(b)/(c) Waiver.

Draft Number: S208-PCS35245-MG-9

Sequential Referral: None

Recommended Referral: None

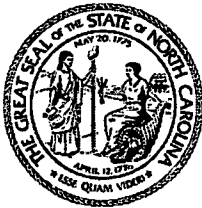
Long Title Amended: No

TOTAL REPORTED: 1

Senator Tommy Tucker will handle SB 208



* C M R 1 8 4 - V - 3 *



SENATE BILL 208: Effective Operation of 1915(b)/(c) Waiver

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Tucker, Barringer
Analysis of: PCS to First Edition
S208-CSMG-9

Date: March 26, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *The Proposed Committee Substitute (PCS) for Senate Bill 208 outlines actions required of the Secretary of the Department of Health and Human Services with regard to Local Management Entities/Managed Care Organizations (LME/MCOs) contracted to operate under the 1915(b)/(c) Medicaid Waiver.*

CURRENT LAW:

S.L. 2011-264 (HB 916), as amended by Section 13, S.L. 2012-151, directed the Department of Health and Human Services (DHHS) to proceed with statewide restructuring of the management responsibilities for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through the expansion of the 1915(b)/(c) Medicaid Waiver. The law as amended specified requirements for DHHS while implementing the restructuring and expansion of services. Below are dates and corresponding requirements.

August 1, 2011: DHHS to select Local Management Entities (LMEs) that had been assessed to meet minimum criteria for Waiver operation.

October 1, 2011: DHHS, with input from others, to submit a strategic plan delineating strategies and agency responsibilities for the achievement of specific objectives and deadlines.

January 1, 2013: For LMEs that had not been approved to operate a 1915(b)/(c) Waiver, DHHS was to require them to merge, or be aligned through an interlocal agreement, with an approved LME. For any LME failing to comply or failing to meet performance requirements of an approved contract, the DHHS must assign management responsibility for the 1915(b)/(c) Waiver to an LME that is successfully operating the waiver.

Periodic: DHHS required to provide periodic status reports to the General Assembly.

July 1, 2013: Completion date for expansion of the 1915(b)/(c) Waiver.

BILL ANALYSIS:

Sections 1 and 2 of the PCS for SB 208 amend Chapter 122C which provides for mental health services.

Section 1 sets out a new definition in G.S. 122C-3, to define "local management entity/managed care organization" or "LME/MCO" as a Local Management Entity (LME) approved by the Department of Health and Human Services to operate the 1915(b)/(c) Medicaid Waiver.

Section 2 adds a new section, G.S. 122C-124.2, to Article 4, Part 2, of Chapter 122C, requiring certain actions by the Secretary of the Department of Health and Human Services (DHHS) relating to the management of behavioral health services under the 1915(b)/(c) Medicaid Waiver. Actions by the Secretary fall into three broad categories under G.S. 122C-124.2:

- a) the Secretary certifies that each LME/MCO is in compliance with requirements specified in subsection (a); or



- b) the Secretary is unable to provide the LME/MCO with certification of compliance with requirements specified in subsection (a); or
- c) the Secretary determines the LME/MCO is not in compliance with requirements other than those specified in subsection (a).

Subsections added to G.S. 122C-124.2. by Section 2 of the PCS:

Subsection (a) provides that for those LME/MCOs with which the DHHS has contracted to operate the 1915(b)/(c) Medicaid Waiver for less than three years, the DHHS Secretary must certify every six months that the LME/MCO is in compliance with the requirements specified. For those LME/MCOs with which the DHHS has contracted to operate for at least three years, the Secretary shall annually certify compliance with the requirements specified. The Secretary's certification must be in writing, include the Secretary's signature, and include a clear and unequivocal statement that the Secretary has determined the LME/MCO is in full compliance with certain requirements. A summary of the requirements are as follows:

- (1) LME/MCO has made adequate provisions against the risk of insolvency with respect to capitation payments for Medicaid enrollees. This means the Secretary must: (i) certify that the LME/MCO has submitted to the DHHS the financial records and reports, required pursuant to its contract, to operate the 1915(b)/(c) Waiver, including monthly balance sheets delineating Medicaid and non-Medicaid funding sources; (ii) determine there are no consecutive three-month periods during which the LME/MCO's ratio of assets to liabilities¹ is less than 1.0, based on a monthly review of the LME/MCO's balance sheets for each of the three months; and (iii) certify that based on a quarterly review of financial reports, an Intra-Departmental Monitoring Team, utilizing the team's solvency measures, has determined the LME/MCO has made adequate provisions against the risk of insolvency.
- (2) LME/MCO is making timely provider payments. An LME/MCO would not be deemed to be making timely provider payments if for any three consecutive months the LME/MCO pays less than 90% of clean claims² for covered services within the 30-day period following receipt by the LME/MCO.
- (3) LME/MCO is exchanging billing, payment, and transaction information with the DHHS and providers in a manner that complies with all applicable federal standards.

Subsection (b) pertains to actions required by the DHHS Secretary when she is unable to certify that an LME/MCO is in compliance with requirements (1)-(3) provided in subsection (a). In the event that the Secretary is unable to certify compliance, no later than 30 days after the Secretary's certification would have been due, the Secretary and the LME/MCO must complete negotiations for the assignment of all the noncompliant LME/MCO's contracts with the DHHS to a compliant LME/MCO and effectuate an orderly transfer of management responsibilities, including the responsibility of paying providers for covered services to ensure the uninterrupted provision of medically necessary services. The bill further specifies that the DHHS is not liable for debts of the noncompliant LME/MCO.

Subsection (c) pertains to actions required by the Secretary when an LME/MCO is not in compliance with a requirement other than those provided in subsection (a)(1)-(3). In the event that the Secretary makes this determination, then no later than 30 days after the Secretary's determination, the Secretary and the LME/MCO must complete negotiations for the assignment of the all the noncompliant LME/MCO's contracts with the DHHS to a compliant LME/MCO and effectuate an orderly transfer of

¹ The bill specifies that the computation of this ratio does not include the State single stream funding or other sources of funds that are not Medicaid funds.

² The bill specifies that the definition for "clean claims" is consistent with the definition in 42 C.F.R. 447.45.

Senate PCS 208

Page 3

management responsibilities, including the responsibility of paying providers for services to ensure the uninterrupted provision of medically necessary services. The bill further specifies that the DHHS is not liable for debts of the noncompliant LME/MCO.

Subsection (d) requires the Secretary to provide a copy of each written, signed certification of an LME/MCO's compliance with the requirements contained in G.S. 122C-124.2, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

Section 3 of the PCS requires that no later than August 1, 2013, the Secretary must complete an initial certification of compliance, in accordance with G.S. 122C-124.2(a), for each LME/MCO that has been approved by the DHHS to operate the 1915(b)/(c) Medicaid Waiver. The Secretary is required to provide a copy of the certification to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

Section 4 of the PCS provides that notwithstanding any law to the contrary, the requirements specified in S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, remain in effect until repealed in whole or in part by an act of the General Assembly.

EFFECTIVE DATE: SB 208 would become effective when it becomes law.

BACKGROUND:

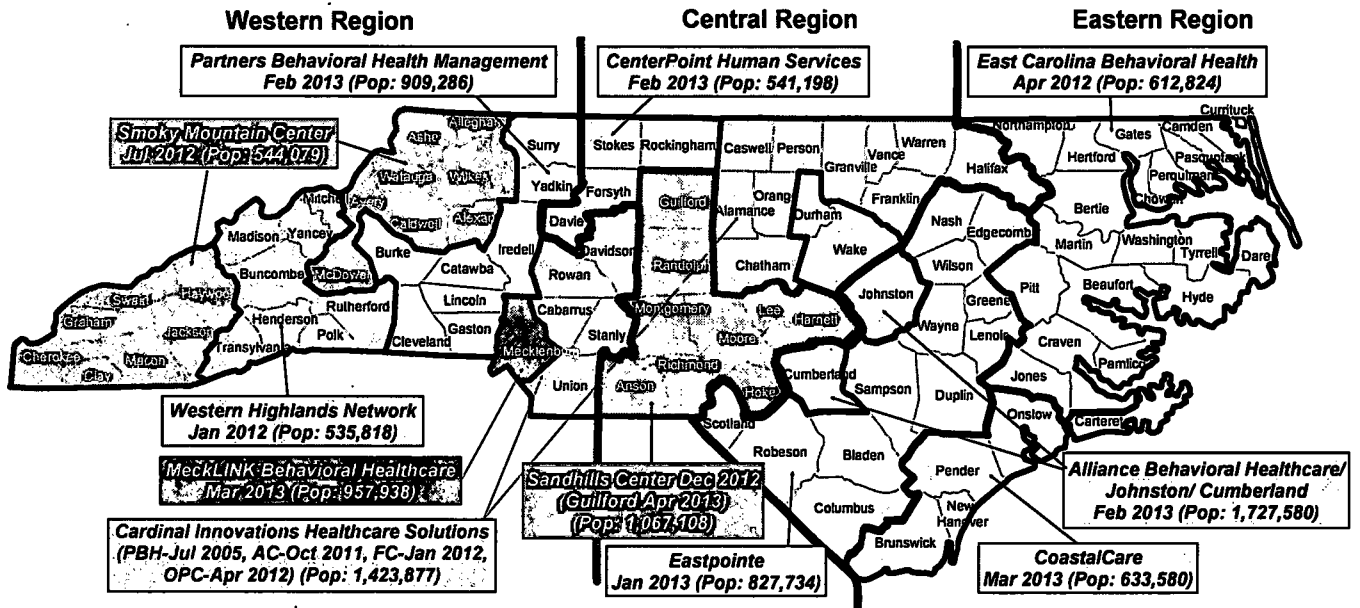
1915(b)/(c) Medicaid Waiver refers to two sections of the Social Security Act allowing states to apply for a waiver from Medicaid policy.

- A 1915(b) waiver would allow a state to provide services through managed care systems or to otherwise limit the choice of providers.
- A 1915(c) waiver would allow a state to provide services in a home and community setting rather than an institutional setting.
- States may also elect to concurrently implement two types of waivers. Currently 99 counties in North Carolina operate under a 1915(b)/(c) waiver. Guilford is expected to come online 4/1/13.

According to the DHHS, Readiness Reviews evaluate whether a Local Management Entity (LME) has the infrastructure necessary to operate as a Managed Care Organization (MCO). They are completed 120 days and 60 days prior to an LME becoming an MCO and additional reviews may be conducted based on the results of the initial review. Annual reviews will occur post transition. Reviews include two tracks: Administrative and Clinical. The Administrative track reviews IT, Claims, and Finance. The Clinical track reviews Customer Services, Quality Management, Provider Network Management, Utilization Management/Care Management and Care Coordination.

The LME/MCO Map on the following page was provided by the Department of Health and Human Services.

Local Management Entity - Managed Care Organizations (LME-MCOs) 1915 b/c Medicaid Waiver Implementation Dates and Population



- For proposed LME-MCOs that have not yet merged, the lead LME name is shown first.
- Dates shown through February 2013 are actual Waiver start dates.
- Dates after February 2013 are the planned Waiver start dates.
- Reflects plans and accomplishments as of February 21, 2013.
- Population is NC OSBM July 2012 population estimates, updated 5/8/12.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 208
PROPOSED COMMITTEE SUBSTITUTE S208-CSMG-9 [v.6]

3/26/2013 5:52:41 PM

Short Title: Effective Operation of 1915(b)/(c) Waiver.

(Public)

Sponsors:

Referred to:

March 7, 2013

A BILL TO BE ENTITLED
AN ACT TO ENSURE EFFECTIVE STATEWIDE OPERATION OF THE 1915 (B)/(C)
MEDICAID WAIVER.

Whereas, S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, required the Department of Health and Human Services (Department) to restructure the statewide management of the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through the statewide expansion of the 1915(b)/(c) Medicaid Waiver; and

Whereas, a local management entity/managed care organization (LME/MCO) that is awarded a contract to operate the 1915(b)/(c) Medicaid Waiver must maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model; and

Whereas, LME/MCOs are acting as Medicaid vendors and the Department must ensure that they are compliant with the provisions of S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, as well as all applicable federal, State, and contractual requirements; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO"
means an LME that has been approved by the Department to operate the
1915(b)/(c) Medicaid Waiver."

SECTION 2. Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under the 1915(b)/(c) Medicaid Waiver.

(a) For LME/MCOs with which the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for less than three years, the Secretary shall certify every six months that the LME/MCO is in compliance with the requirements of subdivisions (1) through (3) of this subsection. For LME/MCOs with which the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for at least three years, the Secretary shall annually certify that the LME/MCO is in compliance with the requirements of subdivisions (1) through (3) of this subsection. The Secretary's certification shall be in writing, include the Secretary's signature, and include a clear and unequivocal statement that the Secretary has determined the LME/MCO to be in full compliance with all of the following requirements:

(1) The LME/MCO has made adequate provisions against the risk of insolvency with respect to capitation payments for Medicaid enrollees. The Secretary



* S 2 0 8 - C S M G - 9 - V - 6 *

shall certify that an LME/MCO has made adequate provision against the risk of insolvency if all of the following are true:

- a. The LME/MCO has submitted to the Department all the financial records and reports it is required to submit to the Department pursuant to the LME/MCO's contract with the Department to operate the 1915(b)/(c) Medicaid Waiver, including monthly balance sheets broken down by Medicaid and non-Medicaid funding sources.
- b. The Secretary determines there are no consecutive three-month periods during which the LME/MCO's ratio of assets to liabilities is less than 1.0., based on a monthly review of the LME/MCO's balance sheets for each month of the three-month period. The computation of the ratio does not include the State single stream funding or other sources of funds that are not Medicaid funds.
- c. An Intra-Departmental Monitoring Team, utilizing the monitoring team's solvency measures, determines that the LME/MCO has made adequate provisions against the risk of insolvency, based on a quarterly review of the financial reports submitted to the Department by the LME/MCO.

(2) The LME/MCO is making timely provider payments. The Secretary shall certify that an LME/MCO is making timely provider payments if there are no consecutive three-month periods during which the LME/MCO paid less than ninety percent (90%) of clean claims for covered services within the 30-day period following the LME/MCO's receipt of these claims. As used in this subdivision, "clean claims" is as defined in 42 C.F.R. 447.45: a claim that can be processed without obtaining additional information from the provider of the service or from a third party. The term includes a claim with errors originating in the LME/MCO's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud or abuse, or a claim under review for medical necessity.

(3) The LME/MCO is exchanging billing, payment, and transaction information with the Department and providers in a manner that complies with all applicable federal standards including, but not limited to, all of the following:

- a. Standards for information transactions and data elements specified in 42 U.S.C. 1302d-2 of the Healthcare Insurance Portability and Accountability Act (HIPAA), as from time to time amended.
- b. Standards for health care claims or equivalent encounter information transaction specified in HIPAA regulations in 45 C.F.R. 162.1102, as from time to time amended.
- c. Implementation specifications for Electronic Data Interchange standards published and maintained by the Accredited Standards Committee (ASC X12) and referenced in HIPAA regulations in 45 C.F.R. 162.920.

(b) If the Secretary is unable to provide an LME/MCO with the certification of compliance required by this section on the date the certification is due because the LME/MCO has failed to comply with any of the requirements specified in subdivisions (1) through (3) of subsection (a) of this section, then not later than 30 days after the Secretary's certification of compliance was due for the LME/MCO, the Secretary and the LME/MCO shall complete negotiations for the assignment of all the noncompliant LME/MCO's contracts with the Department to a compliant LME/MCO. Upon assigning a contract pursuant to this subsection,

1 the Secretary shall effectuate an orderly transfer of management responsibilities from the
2 noncompliant LME/MCO to the compliant LME/MCO, including the responsibility of paying
3 providers for covered services, in order to ensure the uninterrupted provision of medically
4 necessary services to Medicaid recipients. Nothing in this subsection shall be construed to
5 make the Department liable for any debts of the noncompliant LME/MCO.

6 (c) If, in the Secretary's determination, an LME/MCO is not in compliance with a
7 requirement other than those specified in subdivisions (1) through (3) of subsection (a) of this
8 section, then not later than 30 days after the Secretary's determination, the Secretary and the
9 LME/MCO shall complete negotiations for the assignment of all the noncompliant
10 LME/MCO's contracts with the Department to a compliant LME/MCO. Upon assigning a
11 contract pursuant to this subsection, the Secretary shall effectuate an orderly transfer of
12 management responsibilities from the noncompliant LME/MCO to the compliant LME/MCO,
13 including the responsibility of paying providers for covered services, in order to ensure the
14 uninterrupted provision of medically necessary services to Medicaid recipients. Nothing in this
15 subsection shall be construed to make the Department liable for any debts of the noncompliant
16 LME/MCO.

17 (d) The Secretary shall provide a copy of each written, signed certification of
18 compliance completed in accordance with this section to the Senate Appropriations Committee
19 on Health and Human Services, the House Appropriations Subcommittee on Health and Human
20 Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal
21 Research Division."

22 **SECTION 3.** By no later than August 1, 2013, the Secretary of Health and Human
23 Services shall complete an initial certification of compliance, in accordance with
24 G.S. 122C-124.2(a), for each LME/MCO that has been approved by the Department to operate
25 the 1915(b)/(c) Medicaid Waiver and provide a copy of the certification to the Senate
26 Appropriations Committee on Health and Human Services, the House Appropriations
27 Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health
28 and Human Services, and the Fiscal Research Division.

29 **SECTION 4.** Notwithstanding any provision of law to the contrary, all
30 requirements specified in S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, remain
31 in effect until repealed in whole or in part by an act of the General Assembly.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 208

Short Title: Effective Operation of 1915(b)/(c) Waiver. (Public)

Sponsors: Senators Tucker, Barringer (Primary Sponsors); Clark and Hise.

Referred to: Health Care.

March 7, 2013

A BILL TO BE ENTITLED
AN ACT TO ENSURE EFFECTIVE STATEWIDE OPERATION OF THE 1915 (B)/(C)
MEDICAID WAIVER.

Whereas, S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, required the Department of Health and Human Services (Department) to restructure the statewide management of the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through the statewide expansion of the 1915(b)/(c) Medicaid Waiver; and

Whereas, local management entities (LMEs) that are awarded contracts to operate the 1915(b)/(c) Medicaid Waiver must maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model; and

Whereas, these LMEs are acting as Medicaid vendors and the Department must ensure that they are compliant with the provisions of S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, as well as all applicable federal, State, and contractual requirements; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO"
means an LME that has been approved by the Department to operate the
1915(b)/(c) Medicaid Waiver."

SECTION 2. Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under the 1915(b)/(c) Medicaid Waiver.

(a) For LME/MCOs with whom the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for less than three years, the Secretary shall provide an unqualified attestation every six months that the LME/MCO is in compliance with (i) the terms of its contract with the Department, (ii) S.L. 2011-264, as amended by Section 13 of S.L. 2012-151, and (iii) all other applicable State and federal requirements. For LME/MCOs with whom the Department has contracted to operate the 1915(b)/(c) Medicaid Waiver for at least three years, the Secretary shall provide this unqualified attestation of compliance in writing on an annual basis. The Secretary shall specifically address the following requirements in each attestation:

(1) Solvency.

(2) Timeliness of provider payments.



- 1 (3) Compliance with the requirements of S.L. 2011-264, as amended by Section
2 13 of S.L. 2012-151.
- 3 (4) Compliance with the provisions of any contract in effect between the
4 LME/MCO and the Department with respect to management responsibilities
5 for the delivery of services for individuals with mental illness, intellectual or
6 other developmental disabilities, and substance abuse disorders under the
7 1915(b)/(c) Medicaid Waiver.
- 8 (5) The ability to exchange billing, payment, and transaction information with
9 LME/MCOs and providers in a manner that complies with all applicable
10 federal standards, including but not limited to all of the following.
- 11 a. Standards for information transactions and data elements specified in
12 42 U.S.C. 1302d-2 of the Healthcare Insurance Portability and
13 Accountability Act (HIPAA), as from time to time amended.
- 14 b. Standards for health care claims or equivalent encounter information
15 transaction specified in HIPAA regulations in 45 C.F.R. 162.1102, as
16 from time to time amended.
- 17 c. Implementation specifications for Electronic Data Interchange
18 standards published and maintained by the Accredited Standards
19 Committee (ASC X12) and referenced in HIPAA regulations in 45
20 C.F.R. 162.920.
- 21 (b) If the Secretary is unable to provide an LME/MCO with the unqualified attestation
22 of compliance required by subsection (a) of this section on the date the attestation is due
23 because the LME/MCO is noncompliant, then the Secretary shall assign the LME/MCO's
24 contract to operate the 1915(b)/(c) Medicaid Waiver to another LME/MCO no later than thirty
25 days after the Secretary's unqualified attestation of compliance was due for the LME/MCO.
26 Upon assigning a contract pursuant to this subsection, the Secretary shall effectuate an orderly
27 transfer of management responsibilities from the noncompliant LME/MCO to a compliant
28 LME/MCO, including the responsibility of paying providers for covered services, in order to
29 ensure uninterrupted provision of medically necessary services to Medicaid recipients.
- 30 (c) The Secretary shall provide a copy of each unqualified attestation of compliance
31 completed in accordance with this section to the Senate Appropriations Committee on Health
32 and Human Services, the House Appropriations Subcommittee on Health and Human Services,
33 the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research
34 Division."

35 **SECTION 3.** By no later than June 30, 2013, the Secretary of Health and Human
36 Services shall complete an initial unqualified attestation of compliance, in accordance with
37 G.S. 122C-124.2(a), for each LME that has been approved by the Department to operate the
38 1915(b)/(c) Medicaid Waiver and provide a copy of the attestation to the Senate Appropriations
39 Committee on Health and Human Services, the House Appropriations Subcommittee on Health
40 and Human Services, the Legislative Oversight Committee on Health and Human Services, and
41 the Fiscal Research Division.

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

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE

Name of Committee

3-22-19

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Thurman	Elia
Wendy/Clark	Poling Group
Allison Walden	Nelson Mullins
Jill Magner	GAMJ Assoc
Elkison	NCHA
Lauren Asher	NASW-NC
Doug Miskiew	PSG
Joc Dugan	SCNC
Annell Celolph	Dolph LLC
Ann Duke	Beverly
Dana Higo's MD	NC Child Treatment Program
Deb Clary	NC Strategy Partners
Betsy Vetter	AHA
Ben Connell	M.D. Pines

Name	Agency
Liza Kammholz	ECBA

Tracy Hayes	Alliance BHC

Ann Rodriguez	NC Council of Comm Programs

Van Coughlin	"

Cody Hand	NCHA

Kim Coughlin	NCBA

Heather Barnett	WFS

Holly Connor	Catawba Valley Medical Center / AORN

Michele McGlamery	CUMC / AORN

Christine Wilson	ACS CAN

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE
Name of Committee

3-27-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME

FIRM OR AGENCY AND ADDRESS

Abigail Tronch	NCAAC
Jim Farrell	HA
Andy Chase	KMA
Matt Viol	CW Consult
Alex Badger	CSS
Susanna Davis	Williams Mullen
Peppermint	S
Susan Winters	S
Emily Hawthorne	NCAAC, NCAP
Kathy Baker	Eastpointe

3/27/13

NAME AGENCY

Sarah Wolfe

MWCLC

Adam Shlar

DHHS

Coral Stecker

DHHS/DMA

Kelly Crosbie

DHHS/DMA

Courtney Cantrell

DHHS/DMA

Pam Shipman

Cardinal Innovations

JEFF BARNHART

MWC

VISITOR REGISTRATION SHEET

~~HEALTH~~
Education/Higher Education
(Committee Name)

3-27-13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Deb Clary	NC Strategy Partners
Doug Haynes	Rocky Mount Prep Charter School
Elaine Franklin	NCCAT
Jim Dym	Ed Consultant
PAUL J. NORCROSS	PHOENIX ACADEMY
Baker A. Mitchell, Jr	NC Alliance For Public Charter Schools
Tim Mulcahy	NCLC
Gene Causby	NC SCA
TOM VITACIAR	ASC
Leanne Wimmer	NC SBA
TODD HARRIS	UNION ACADEMY CHARTER SCHOOL
Jason Deans	JDA
GRACE TRILLING	Cumstrat
Martez Ali	SBE
Doug Miskew	PSG
Townes Maxwell	PSG
Lexi Schmitt	UNC-CH

**Senate Committee on Health Care
Wednesday, April 3, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on April 3, 2013 in Room 544 of the Legislative Office Building. Twelve members were present.

Senator Louis Pate, Chair, presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms for the meeting: Billy Fritchner, Ken Kirby, Canton Lewis, Ashley Mickens and Steve Wilson. He also recognized the following Pages assisting with the meeting: Haley Ashley and Caroline Kerns from Burlington, Courtney Baptiste of Chapel Hill, Sterrett Brook of Raleigh, Catherine Potter of Wilson and Harrison Rhoades of Raleigh.

Senator Goolsby was recognized to explain SB 240, "Develop Rules for Release of Path Materials." Senator Woodard made a motion for the bill to receive a Favorable Report. The motion carried.

Senator Pate turned the podium over to Senator Hise. Senator Hise then recognized Senator Pate to explain SB 336 "Collaboration Among State diabetes Programs." After explaining the bill, a motion was made by Senator Tucker for the PCS to receive a Favorable Report with Unfavorable as to the Original Bill. Motion carried.

The meeting adjourned at 11:20 am.



Senator Louis Pate, Chair
Presiding



Edna Pearce, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
nt: Monday, April 01, 2013 01:25 PM
to: Sen. Thom Goolsby; Sen. Louis Pate
Cc: Joseph Kyzer (Sen. Thom Goolsby); Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wednesday, April 03, 2013 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 3, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 240	Develop Rules for Release of Path Materials.	Senator Goolsby
SB 336	Collaboration Among State Diabetes Programs.	Senator Pate

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, April 03, 2013

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

FAVORABLE

SB 240

Develop Rules for Release of Path Materials.

Draft Number: None

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Senator Thomas Goolsby will handle SB 240



★ C M R 2 1 2 - V - 2 ★

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, April 03, 2013

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

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

SB 336

Collaboration Among State Diabetes Programs.

Draft Number: S336-PCS35309-SH-2

Sequential Referral: None

Recommended Referral: None

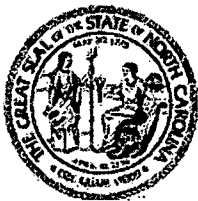
Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Louis Pate will handle SB 336



★ C M R 2 2 3 - V - 1 ★



SENATE BILL 240: Develop Rules for Release of Path Materials

2013-2014 General Assembly

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

Date: April 1, 2013
Prepared by: Barbara Riley
Committee Counsel

SUMMARY: *Senate Bill 240 is a recommendation of the Legislative Research Commission from its Committee on Pathological Materials. The bill directs the Division of Health Services Regulation in the Department of Health and Human Services and the North Carolina Medical Board to adopt rules governing procedures for requesting and releasing pathological materials from clinical laboratories within the jurisdiction of the Department or the Board. The rules to be adopted must be consistent with the North Carolina Hospital Association Best Practices Principles and the College of American Pathologists 2003 Professional Relations Manual. The Department and the Board are to consult with each other in the development of the rules to ensure consistency.*

[As introduced, this bill was identical to H168, as introduced by Rep. Murry, which is currently in House Health and Human Services.]

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

O. Walker Reagan
Director



Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 336*

Short Title: Collaboration Among State Diabetes Programs.

(Public)

Sponsors: Senators Pate (Primary Sponsor); and Hise.

Referred to: Health Care.

March 19, 2013

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DIVISION OF MEDICAL ASSISTANCE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE DIVISION OF PUBLIC HEALTH OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE DEPARTMENT OF THE STATE TREASURER TO COLLABORATE WITH ONE ANOTHER REGARDING ACTIVITIES AND PROGRAMS AIMED AT DIABETES PREVENTION, CONTROL, AND CARE AND TO REQUIRE A REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES AND THE FISCAL RESEARCH DIVISION REGARDING THESE PROGRAMS ADDRESSING DIABETES.

Whereas, approximately 1.2 million people are living with diabetes in North Carolina, accounting for 12% of the population, and the rate of diabetes is predicted to increase by 66% by 2025; and

Whereas, North Carolina is ranked 42nd in the area of diabetes in the 2012 American Health Rankings report; and

Whereas, according to the Centers for Disease Control indicates diabetes is the leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of blindness and other chronic diseases among adults in the United States; and

Whereas, chronic diseases and related injuries are responsible for approximately two-thirds of all deaths in North Carolina; therefore effective coordination and utilization of resources addressing diabetes and other chronic diseases would benefit all North Carolina residents; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 3 of Article 7 of Chapter 130A of the General Statutes is amended by adding a new section to read:

"§ 130A-221.1. Coordination of diabetes programs.

(a) The Division of Medical Assistance of the Department, the Diabetes Prevention and Control Branch of the Division of Public Health in the Department, and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees shall collaborate to identify goals and benchmarks while also developing individual entity plans to reduce the incidence of diabetes in North Carolina, improve diabetes care, and control complications associated with diabetes.

(b) The Division of Medical Assistance of the Department, the Diabetes Prevention and Control Branch of the Division of Public Health in the Department, and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees shall submit a report to the Joint Legislative Oversight Committee on Health and



* S 3 3 6 - V - 1 *

Human Services and the Fiscal Research Division by January 1 of each odd-numbered year.
The report shall address the following matters:

- (1) The financial impact and reach that diabetes of all types is having on the agency, the State, and localities. Items included in this assessment shall include the number of lives with diabetes impacted by prevention and diabetes control programs implemented by the agency, the financial toll or impact diabetes and its complications places on the program, and the financial toll or impact diabetes and its complications places on the program in comparison to other chronic diseases and conditions.
- (2) An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment shall also document the amount and source for any funding directed to the agency from the North Carolina General Assembly for programs and activities aimed at reaching those with diabetes.
- (3) A description of the level of coordination existing between the Divisions with regards to activities, programs, and messaging on managing, treating, or preventing all forms of diabetes and its complications.
- (4) The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the General Assembly. The plans shall identify proposed action steps to reduce the impact of diabetes, pre-diabetes, and related diabetic complications. The plans shall also identify expected outcomes of the action steps proposed and establish benchmarks for controlling and preventing diabetes.
- (5) The development of a detailed budget identifying needs, costs, and resources required to implement the plans identified in subdivision (4) of this subsection."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 336*
PROPOSED COMMITTEE SUBSTITUTE S336-PCS35309-SH-2

Short Title: Collaboration Among State Diabetes Programs.

(Public)

Sponsors:

Referred to:

March 19, 2013

A BILL TO BE ENTITLED
AN ACT REQUIRING THE DIVISIONS OF MEDICAL ASSISTANCE AND PUBLIC
HEALTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
AND THE STATE HEALTH PLAN DIVISION WITHIN THE DEPARTMENT OF THE
STATE TREASURER, TO COORDINATE THE DIABETES PROGRAMS THEY EACH
ADMINISTER; TO EACH DEVELOP PLANS TO REDUCE THE INCIDENCE OF
DIABETES, TO IMPROVE CARE, AND TO CONTROL COMPLICATIONS; AND TO
REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH
AND HUMAN SERVICES AND THE FISCAL RESEARCH DIVISION.

Whereas, approximately 1.2 million people are living with diabetes in North
Carolina, accounting for 12% of the population, and the rate of diabetes is predicted to increase
by 66% by 2025; and

Whereas, North Carolina is ranked 42nd in the area of diabetes in the 2012
American Health Rankings report; and

Whereas, according to the Centers for Disease Control indicates diabetes is the
leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of
blindness and other chronic diseases among adults in the United States; and

Whereas, chronic diseases and related injuries are responsible for approximately
two-thirds of all deaths in North Carolina making effective coordination and utilization of
resources addressing diabetes and other chronic diseases beneficial to all North Carolina
residents; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 3 of Article 7 of Chapter 130A of the General Statutes is
amended by adding a new section to read:

"§ 130A-221.1. Coordination of diabetes programs.

**(a) The Division of Medical Assistance and the Diabetes Prevention and Control
Branch of the Division of Public Health, within the Department of Health and Human Services;
in addition to the State Health Plan Division within the Department of State Treasurer; shall
work collaboratively to each develop plans to reduce the incidence of diabetes, to improve
diabetes care, and to control the complications associated with diabetes. Each entity's plans
shall be tailored to the population the entity serves and must establish measurable goals and
objectives.**

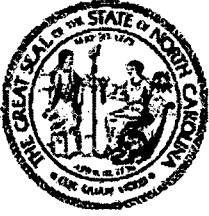
**(b) On or before December 1 of each even-numbered year, the entities referenced in
subsection (a) of this section shall collectively submit a report to the Joint Legislative Oversight
Committee on Health and Human Services and the Fiscal Research Division. The report shall
provide the following:**



* S 3 3 6 - P C S 3 5 3 0 9 - S H - 2 *

- (1) An assessment of the financial impact that each type of diabetes has on each entity and collectively on the State. This assessment shall include: the number of individuals with diabetes served by the entity, the cost of diabetes prevention and control programs implemented by the entity, the financial toll or impact diabetes and related complications places on the program, and the financial toll or impact diabetes and related complications places on each program in comparison to other chronic diseases and conditions.
- (2) A description and an assessment of the effectiveness of each entity's programs and activities implemented to prevent and control diabetes. For each program and activity, the assessment shall document the source and amount of funding provided to the entity, including funding provided by the State.
- (3) A description of the level of coordination that exists among the entities referenced in subsection (a) of this section, as it relates to activities, programs, and messaging to manage, treat, and prevent all types of diabetes and the complications from diabetes.
- (4) The development of and revisions to detailed action plans for preventing and controlling diabetes and related complications. The plans shall identify proposed action steps to reduce the impact of diabetes, pre-diabetes, and related diabetic complications; identify expected outcomes for each action step; and establish benchmarks for preventing and controlling diabetes.
- (5) A detailed budget identifying needs, costs, and resources required to implement the plans identified in subdivision (4) of this subsection, including a list of actionable items for consideration by the Committee."

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



SENATE BILL 336: Collaboration Among State Diabetes Programs

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Pate
Analysis of: PCS to First Edition
S336-CSSH-2

Date: April 2, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *The Proposed Committee Substitute (PCS) for SB 336 requires the Division of Medical Assistance, and the Diabetes Prevention and Control Branch, Division of Public Health, within the Department of Health and Human Services; and the State Health Plan Division within the Department of the State Treasurer; to collectively report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on each entity's plans to reduce the incidence of diabetes, improve care, and control complications for the populations they serve.*

The PCS primarily makes stylistic changes, but does change the reporting date so that the entities report one month earlier than the original bill.

BILL ANALYSIS: Chapter 103A. Public Health, Article 7. Chronic Disease, Part 3. Glaucoma and Diabetes, currently contains G.S. 130A-221 authorizing the Department of Health and Human Services (DHHS) to establish and administer a program for the detection, prevention, and the care and treatment of persons with glaucoma and diabetes. Senate Bill 336 adds G.S. 130A-221.1 to Part 3, Article 7, Chapter 130A, to provide for coordination of diabetes programs.

The bill requires the following divisions to develop plans for the populations they serve that will reduce the incidence of diabetes, improve diabetes care, and control complications associated with diabetes:

- Division of Medical Assistance, DHHS
- Diabetes Prevention and Control Branch, Division of Public Health, DHHS
- State Health Plan Division, Department of the State Treasurer

On or before December 1 of each even-numbered year, the above entities must collectively submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report must include the following:

- An assessment of the financial impact that each type of diabetes has on each entity and collectively on the State.
- A description and assessment of the effectiveness of each entity's programs and activities implemented to prevent and control diabetes.
- A description of the level of coordination that exists among the entities.
- The development of and revisions to detailed action plans for preventing and controlling diabetes and related complications
- A detailed budget identifying needs, costs, and resources required to implement the plans.

EFFECTIVE DATE: Senate Bill 336 would become effective when it becomes law.

BACKGROUND: The Centers for Disease Control and Prevention (CDC) released the 2012 Diabetes Report Card providing a state and national snapshot of diabetes and its complications. The report defines diabetes as follows:

O. Walker Reagan
Director



Research Division
(919) 733-2578

"Diabetes is a group of diseases characterized by high blood glucose (blood sugar). When a person has diabetes, the body either does not produce enough insulin or is unable to use its own insulin effectively. Glucose builds up in the blood and causes a condition that, if not controlled, can lead to serious health complications and even death. The risk of death for a person with diabetes is twice the risk of a person of similar age who does not have diabetes. Diabetes is a major cause of heart disease and stroke."

The most common forms of diabetes are: Type 1 (accounts for about 5% of all diagnosed cases, generally occurs in children and those under 30), Type 2 (accounts for about 95% of diagnosed cases in adults), and Gestational (develops in 2-10% of pregnant women).

The Diabetes Prevention and Control Branch, Division of Public Health, DHHS, produced a report in 2008, The Burden of Diabetes in North Carolina: Prevalence, Complications and Costs, and more recently there is a Presentation in 2010 and a Fact Sheet.

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

April 3rd, 2013

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
CSA	TSS
Bill Scobbin	TSS
~~Shayla Nunn~~	Nord
~~Robin Hartman~~	~~NC Psychiatric Assoc~~
Keith McCoy	↓
Thomas Peters	
Mike L... ..	
Amy Whited	NCMS
Lorene Temming	NCMS
Jim STRAIGHT	AMERICAN DIABETES ASSOC.
DAVID RICE	MFS
Erica Nelson	NCHA
Andy Chase	KMA
Steve Bodge	
DANIEL VAN LIERE	VIDANT HEALTH
Matthew McNeill	Coastal Health
BJ Miller	Coastal

VISITOR REGISTRATION SHEET

Senate Committee on Health Care
(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Sarah Wolf	MWC LLC
John Harsh	MF & S
April Reese	PHHS
Chris Harsh	DHHS / DPH
Synetha John	NCPA
Tracy Johnson	Visitor
Shirley Corcoran	NCAORN
Alan Briggs	NC Food Banks
JAY PETERS	CSS
Judy Jenkins	OAPI
JESSIE GOODMAN	DHHS / DH502
Matthew Barber	NC Chamber
George Smith	Nexsen Pruet
Patrick Limer	none
Mike Earley	Former Gov's Assoc

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 4-3 TIME: 11 AM

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

Page Name	Hometown	Sponsoring Senator
1 Haley Ashley	Burlington	Gunn
2 Caroline Kerns	Burlington	Gunn
3 Courtney Baptiste	Chapel Hill	Kinnard
4 Sterrett Brook	Raleigh	Woodard
5 Catherine Potter	Wilson	Newton
6 Harrison Rhoades	Raleigh	Hunt
7		
8		
9		
10		

Do not add names below the grid.

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

**Senate Committee on Health Care
Wednesday, April 10, 2013, 11:00 AM
544 Legislative Office Building**

Senator Ralph Hise, Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 98	Require Pulse Oximetry Newborn Screening.	Senator Brock Senator Pate Senator Stein
SB 456	Designate Primary Stroke Centers.	Senator Pate Senator Bingham Senator Wade
SB 553	LME/MCO Enrollee Grievances & Appeals.	Senator Hise

Other Business

Adjournment

**Senate Committee on Health Care
Wednesday, April 10, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on April 10, 2013, in Room 544 of the Legislative Office Building. Fifteen members were present.

Senator Ralph Hise, Chair, presided.

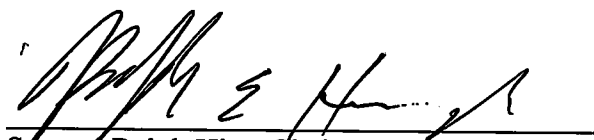
Senator Hise called the meeting to order by recognizing the Pages—Chandria Boykin of Pitt County, Shyheem Carmon of Greene County, Brett Shackleford of Greene County, and Ruth Smith of New Hanover County; and the Sergeants-at-Arms—Billy Fritscher, Ed Kesler, Ken Kirby, Ashley Mickens, and Steve Wilson.

Senator Hise noted that Senate Bill 553 – LME/MCO Enrollee Grievances & Appeals had been withdrawn from consideration.

Senator Brock was recognized to present Senate Bill 98 – Require Pulse Oximetry Newborn Screening. Senator Don Davis moved for a favorable report to the bill; the bill passed.

Senator Pate was recognized to present Senate Bill 456 – Designate Primary Stroke Centers. Senator Pate moved for adoption of the PCS for Senate Bill 456. Senator Robinson moved for a favorable report to the PCS, unfavorable to the original bill. The PCS passed.

The meeting adjourned at 11:49 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

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 10, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 98	Require Pulse Oximetry Newborn Screening.	Senator Brock Senator Pate Senator Stein
SB 456	Designate Primary Stroke Centers.	Senator Pate Senator Bingham Senator Wade
SB 553	LME/MCO Enrollee Grievances & Appeals.	Senator Hise

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, April 10, 2013

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

FAVORABLE

SB 98

Require Pulse Oximetry Newborn Screening.

Draft Number: None

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Senator Andrew Brock will handle SB 98



★ C M R 2 7 0 - V - 1 ★

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Thursday, April 11, 2013

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

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

SB 456

Designate Primary Stroke Centers.

Draft Number: S456-PCS95079-TK-10

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Senator Louis Pate will handle SB 456



★ C M R 2 8 2 - V - 1 ★

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 553

Short Title: LME/MCO Enrollee Grievances & Appeals.

(Public)

Sponsors: Senator Hise (Primary Sponsor).

Referred to: Health Care.

April 1, 2013

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR MEDICAID ENROLLEES OF LOCAL MANAGEMENT ENTITIES THAT HAVE BEEN APPROVED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO OPERATE AS A MANAGED CARE ORGANIZATION UNDER THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a Chapter to read:

"Chapter 108D.

"Enrollee Grievances and Appeals of LME/MCO Managed Care Actions.

"Article 1.

"General Provisions.

"§ 108D-1. Definitions.

The following definitions apply in this Chapter, unless the context clearly requires otherwise:

- (1) Applicant. – A provider of MH/IDD/SA who is seeking to participate in the closed network of one or more LME/MCOs.
- (2) Closed network. – The network of providers who have contracted with an LME/MCO to furnish MH/IDD/SA services to enrollees.
- (3) Contested case hearing. – The hearing or hearings conducted at OAH pursuant to G.S. 108D-8 to resolve a dispute between an enrollee and an LME/MCO about a managed care action.
- (4) Department. – The North Carolina Department of Health and Human Services.
- (5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
- (7) Enrollee. – A Medicaid beneficiary who is currently enrolled in an MCO or PIHP operated by an LME/MCO.
- (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
- (9) Local Management Entity/Managed Care Organization or LME/MCO. – An LME that has been approved by the Department to operate an MCO or PIHP in accordance with 42 C.F.R. Part 438.
- (10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).
- (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
- (12) MH/IDD/SA. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect



between the Department and an LME to operate an MCO or PIHP under the 1915(b)/(c) Medicaid Waivers approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of MH/IDD/SA services who has entered into a contract for participation in the closed network of one or more LME/MCOs. The term also includes a provider of emergency services.

(14) Notice of managed care action. – The notice required by 42 C.F.R. § 438.404.

(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).

(16) OAH. – The North Carolina Office of Administrative Hearings.

(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.

(18) Provider. – As defined in G.S. 108C-2(10).

(19) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

"§ 108D-2. Scope; applicability of this Chapter.

This Chapter applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider of an LME/MCO.

"§ 108D-3. Conflicts; severability.

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Part 438, federal law prevails to the extent of the conflict.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for behavioral health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"§ 108D-4. LME/MCO grievance and appeal procedures, generally.

(a) Each LME/MCO shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees, and network providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.

(b) Enrollees, or network providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. However, unless the enrollee or network provider requests an expedited appeal, the oral filing must be followed by a written, signed grievance or appeal.

(c) An LME/MCO shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an LME/MCO level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or network providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) An LME/MCO shall not take punitive action against a network provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

- 1 (2) Requesting an LME/MCO level appeal on behalf of an enrollee or
2 supporting an enrollee's request for an LME/MCO level appeal.
3 (3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or
4 supporting an enrollee's request for an LME/MCO level expedited appeal.
5 (4) Requesting a contested case hearing on behalf of an enrollee or supporting
6 an enrollee's request for a contested case hearing.

7 **"§ 108D-5. LME/MCO grievances.**

8 (a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to
9 act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to
10 express dissatisfaction about any matter other than a managed care action. Upon receipt of a
11 grievance, an LME/MCO shall acknowledge receipt of the grievance in writing by United
12 States mail.

13 (b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance as
14 expeditiously as the enrollee's health condition requires, but no later than 90 days after receipt
15 of the grievance. The LME/MCO shall provide the enrollee and all other affected parties with
16 written notice of the grievance disposition by United States mail within this 90-day period.

17 (c) Right to Request LME/MCO Level Appeal. – An enrollee, or a network provider
18 authorized in writing to act on behalf of an enrollee, may file a request for an LME/MCO level
19 appeal of a grievance disposition pursuant to G.S. 108D-6 as long as the enrollee or network
20 provider has exhausted the grievance procedure described in this section.

21 (d) Notice of Right to Request LME/MCO Level Appeal. – In the same mailing as the
22 grievance disposition, the LME/MCO shall also notify the enrollee of the right to file a request
23 for an LME/MCO level appeal of the grievance disposition pursuant to G.S. 108D-6.

24 **"§ 108D-6. Standard LME/MCO level appeals.**

25 (a) Notice of Managed Care Action. – An LME/MCO shall provide an enrollee with
26 written notice of a managed care action by United States mail in a manner consistent with 42
27 C.F.R. Part 438, Subpart F.

28 (b) Request for Appeal. – An enrollee, or a network provider authorized in writing to
29 act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a
30 grievance disposition or a notice of managed care action no later than 30 days after the mailing
31 date of the grievance disposition or notice of managed care action. Upon receipt of a request for
32 an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal
33 in writing by United States mail.

34 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
35 during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R.
36 § 438.420.

37 (d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as
38 the enrollee's health condition requires, but no later than 45 days after receiving the request for
39 appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written
40 notice of resolution by United States mail within this 45-day period.

41 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
42 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
43 hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the
44 grievance procedures described in G.S. 108D-5, if applicable, and the appeal procedures
45 described in G.S. 108D-6 or G.S. 108D-7.

46 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
47 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
48 contested case hearing that meets the requirements of G.S. 108D-8(e).

49 **"§ 108D-7. Expedited LME/MCO level appeals.**

50 (a) Request for Expedited Appeal. – When the time limits for completing a standard
51 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or

1 regain maximum function, an enrollee, or a network provider authorized in writing to act on
2 behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care
3 action no later than 30 days after the mailing date of the notice of managed care action. For
4 expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee
5 qualifies for an expedited appeal. For expedited appeal requests made by network providers on
6 behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

7 (b) Notice of Denial for Expedited Appeal. – If the LME/MCO denies a request for an
8 expedited LME/MCO level appeal, the LME/MCO shall make reasonable efforts to give the
9 enrollee and all other affected parties oral notice of the denial and follow up with written notice
10 of denial by United States mail by no later than two calendar days after receiving the request
11 for an expedited appeal. In addition, the LME/MCO shall resolve the appeal within the time
12 limits established for standard LME/MCO level appeals in G.S. 108D-6.

13 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
14 during the pendency of an expedited LME/MCO level appeal to the extent required under 42
15 C.F.R. § 438.420.

16 (d) Notice of Resolution. – If the LME/MCO grants a request for an expedited
17 LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the
18 enrollee's health condition requires and no later than three working days after receiving the
19 request for an expedited appeal. The LME/MCO shall provide the enrollee and all other
20 affected parties with a written notice of resolution by United States mail within this three-day
21 period.

22 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
23 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
24 hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the
25 grievance procedures described in G.S. 108D-5, if applicable, and the appeal procedures
26 described in G.S. 108D-6 or G.S. 108D-7.

27 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
28 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
29 contested case hearing that meets the requirements of G.S. 108D-8(e).

30 **"§ 108D-8. Contested case hearings on disputed managed care actions.**

31 (a) Jurisdiction of OAH. – The Office of Administrative Hearings does not have
32 jurisdiction over a dispute concerning a grievance or managed care action, except as expressly
33 set forth in this Chapter.

34 (b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or
35 rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of
36 resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not
37 apply to enrollees contesting a grievance or managed care action.

38 (c) Request for Contested Case Hearing. – A request for an administrative hearing to
39 appeal a notice of resolution issued by an LME/MCO is a contested case subject to the
40 provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or a network
41 provider authorized in writing to act on behalf of an enrollee, has the right to file a request for
42 appeal to contest a notice of resolution as long as the enrollee or network provider has
43 exhausted the grievance procedures described in G.S. 108D-5, if applicable, and the appeal
44 procedures described in G.S. 108D-6 or G.S. 108D-7.

45 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act
46 on behalf of an enrollee, may appeal a notice of resolution by filing an appeal request form that
47 meets the requirements of subsection (e) of this section at OAH and sending a copy of the filing
48 to the affected LME/MCO by no later than 30 days after the mailing date of the notice of
49 resolution. A request for appeal is deemed filed when a completed and signed appeal request
50 form has been both submitted into the care and custody of the chief hearings clerk of OAH and
51 accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form,

1 information contained in the notice of resolution is no longer confidential, and the LME/MCO
2 shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may
3 dispose of these records after one year.

4 (e) Appeal Request Form. – In the same mailing as the notice of resolution, the
5 LME/MCO shall also provide the enrollee with an appeal request form for a contested case
6 hearing which shall be no more than one side of one page. The form shall include at least all of
7 the following:

8 (1) A statement that in order to request an appeal, the enrollee must file the form
9 by mail or fax at the address or fax number listed on the form by no later
10 than 30 days after the mailing date of the notice of resolution.

11 (2) The enrollee's name, address, telephone number, and Medicaid identification
12 number.

13 (3) A preprinted statement that indicates that the enrollee would like to appeal a
14 grievance disposition or a specific managed care action identified in the
15 notice of resolution.

16 (4) A statement informing the enrollee of the right to be represented at the
17 contested case hearing by a lawyer, a relative, a friend, or other
18 spokesperson.

19 (5) A space for the enrollee's signature and date.

20 (f) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
21 during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420.
22 Notwithstanding any other provision of State law, the administrative law judge does not have
23 the power to order and shall not order an LME/MCO to continue benefits in excess of what is
24 required by 42 C.F.R. § 438.420.

25 (g) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
26 150B of the General Statutes, the chief administrative law judge of OAH may limit and
27 simplify the administrative hearing procedures that apply to contested case hearings conducted
28 pursuant to this section in order to complete these cases as expeditiously as possible. Any
29 simplified hearing procedures approved by the chief administrative law judge pursuant to this
30 subsection must comply with all of the following requirements:

31 (1) OAH shall schedule and hear cases by no later than 55 days after receipt of a
32 request for a contested case hearing.

33 (2) OAH shall conduct all contested case hearings telephonically or by video
34 technology with all parties, unless the enrollee requests that the hearing be
35 conducted in person before the administrative law judge. An in-person
36 hearing shall be conducted in Wake County unless the enrollee's
37 impairments limit travel. For enrollees with impairments that limit travel, an
38 in-person hearing shall be conducted in the enrollee's county of residence.
39 OAH shall provide written notice to the enrollee of the use of telephonic
40 hearings, hearings by video conference, and in-person hearings before the
41 administrative law judge, as well as written instructions on how to request a
42 hearing in the enrollee's county of residence.

43 (3) The administrative law judge assigned to hear the case shall consider and
44 rule on all prehearing motions prior to the scheduled date for a hearing on
45 the merits.

46 (4) Neither an enrollee nor an LME/MCO is required to be represented by an
47 attorney at a contested case hearing. For cases in which the enrollee is not
48 represented by an attorney, the administrative law judge assigned to hear the
49 case shall make reasonable efforts to assure a fair hearing and to maintain a
50 complete record of the hearing.

(5) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by United States mail. OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(6) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the LME/MCO in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the Department's expense and made part of the record, including all of the following:

1. A hearing involving medical issues such as a diagnosis, an examining physician's report, or a decision by a medical review team.

2. A hearing in which the administrative law judge considers it necessary to have a medical assessment other than the medical assessment performed by an individual involved in any previous level of review or decision making.

(h) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing pursuant to this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(i) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the LME/MCO's managed care action and regardless of whether the LME/MCO had an opportunity to consider the evidence in resolving the LME/MCO level appeal. Upon the receipt of new evidence and at the request of the LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken against the enrollee, it shall immediately inform the administrative law judge of its decision.

(j) Issue for Hearing. – For each managed care action, the administrative law judge shall determine whether the LME/MCO substantially prejudiced the rights of the enrollee and whether the LME/MCO, based upon evidence at the hearing:

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

(3) Failed to use proper procedure.

(4) Acted arbitrarily or capriciously.

(5) Failed to act as required by law or rule.

(k) To the extent that anything in this Part, Chapter 150B of the General Statutes, or any rules or policies adopted pursuant to these Chapters is inconsistent with the Social Security Act

1 or 42 C.F.R. Subpart F, Part 438, federal law prevails and applies to the extent of the conflict.
2 All rules, rights, and procedures for contested case hearings concerning managed care actions
3 shall be construed so as to be consistent with federal law and shall provide the enrollee with no
4 lesser and no greater rights than those provided under federal law.

5 **"§ 108D-9. Notice of final decision and right to seek judicial review.**

6 The administrative law judge assigned to conduct a contested case hearing pursuant to
7 G.S. 108D-8 shall hear and decide the case without unnecessary delay. The judge shall prepare
8 a written decision that includes findings of fact and conclusions of law and send it to the parties
9 in accordance with G.S. 150B-37. The written decision shall notify the parties of the final
10 decision and of the right of the enrollee and the LME/MCO to seek judicial review of the
11 decision pursuant to Article 4 of Chapter 150B of the General Statutes."

12 **SECTION 2.** G.S. 122C-3 is amended by adding a new subdivision to read:

13 **"(20c) "Local management entity-managed care organization" or "LME/MCO"**
14 **means an LME that has been approved by the Department to operate a**
15 **managed care organization or prepaid inpatient health plan in accordance**
16 **with 42 C.F.R. Part 438."**

17 **SECTION 3.** G.S. 122C-151.3 reads as rewritten:

18 **"§ 122C-151.3. Dispute with area authorities or county programs.**

19 **(a)** An area authority or county program shall establish written procedures for resolving
20 disputes over decisions of an area authority or county program that may be appealed to the
21 State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and
22 shall provide an opportunity for those who dispute the decision to present their position.

23 **(b)** This section does not apply to a grievance or appeal of a managed care action by a
24 Medicaid beneficiary currently enrolled in a managed care organization or a prepaid inpatient
25 health plan operated by an LME/MCO who is subject to Chapter 108D of the General Statutes."

26 **SECTION 4.** G.S. 122C-151.4(g) reads as rewritten:

27 **"(g)** ~~This section does not apply to providers of community support services who appeal~~
28 ~~directly to the Department of Health and Human Services under the Department's community~~
29 ~~support provider appeal process.~~ a grievance or appeal of a managed care action by a Medicaid
30 beneficiary currently enrolled in a managed care organization or a prepaid inpatient health plan
31 operated by an LME/MCO that is subject to Chapter 108D of the General Statutes."

32 **SECTION 5.** G.S. 84-2.1 reads as rewritten:

33 **"§ 84-2.1. "Practice law" defined.**

34 The phrase "practice law" as used in this Chapter is defined to be performing any legal
35 service for any other person, firm or corporation, with or without compensation, specifically
36 including the preparation or aiding in the preparation of deeds, mortgages, wills, trust
37 instruments, inventories, accounts or reports of guardians, trustees, administrators or executors,
38 or preparing or aiding in the preparation of any petitions or orders in any probate or court
39 proceeding; abstracting or passing upon titles, the preparation and filing of petitions for use in
40 any court, including administrative tribunals and other judicial or quasi-judicial bodies, or
41 assisting by advice, counsel, or otherwise in any legal work; and to advise or give opinion upon
42 the legal rights of any person, firm or corporation: Provided, that the above reference to
43 particular acts which are specifically included within the definition of the phrase "practice law"
44 shall not be construed to limit the foregoing general definition of the term, but shall be
45 construed to include the foregoing particular acts, as well as all other acts within the general
46 definition. The phrase "practice law" does not encompass ~~the~~ any of the following:

47 **(1)** The writing of memoranda of understanding or other mediation summaries
48 by mediators at community mediation centers authorized by G.S. 7A-38.5 or
49 by mediators of personnel matters for The University of North Carolina or a
50 constituent institution.

1 (2) The representation of an LME/MCO by an employee or a contractor of the
2 LME/MCO in a contested case hearing under G.S. 108D-8."

3 **SECTION 6.** This act becomes effective July 1, 2013.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

D

**SENATE BILL 553
PROPOSED COMMITTEE SUBSTITUTE S553-CSSH-3 [v.5]**

4/9/2013 5:44:34 PM

Short Title: LME/MCO Enrollee Grievances & Appeals.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR LOCAL
MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION (LME/MCO)
MEDICAID ENROLLEES.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a Chapter to read:

"Chapter 108D.

"LME/MCO Enrollee Grievances and Appeals.

"Article 1.

"General Provisions.

"§ 108D-1. Definitions.

The following definitions apply in this Chapter, unless the context clearly requires otherwise:

- (1) Applicant. – A provider of MH/IDD/SA services who is seeking to participate in the closed network of one or more LME/MCOs.
- (2) Closed network. – A network of providers that have contracted with an LME/MCO to furnish MH/IDD/SA services to enrollees.
- (3) Contested case hearing. – The hearing or hearings conducted at OAH pursuant to G.S. 108D-8 to resolve a dispute between an enrollee and an LME/MCO about a managed care action.
- (4) Department. – The North Carolina Department of Health and Human Services.
- (5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
- (7) Enrollee. – A Medicaid beneficiary who is currently enrolled with an LME/MCO.
- (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
- (9) Local Management Entity/Managed Care Organization or LME/MCO. – An LME that has been approved by the Department to operate the 1915(b)/(c) Medicaid Waiver.
- (10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).
- (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
- (12) MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department and an LME to operate an MCO or PIHP under the



* S 5 5 3 - C S S H - 3 - V - 5 *

1915(b)/(c) Medicaid Waivers approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of MH/IDD/SA services who has entered into a contract for participation in the closed network of one or more LME/MCOs. The term also includes a provider of emergency services.

(14) Notice of managed care action. – The notice required by 42 C.F.R. § 438.404.

(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).

(16) OAH. – The North Carolina Office of Administrative Hearings.

(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.

(18) Provider. – As defined in G.S. 108C-2(10).

(19) Provider of emergency services. – A provider who is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

"§ 108D-2. Scope; applicability of this Chapter.

This Chapter applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider of an LME/MCO.

"§ 108D-3. Conflicts; severability.

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Part 438, federal law prevails to the extent of the conflict.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for behavioral health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"§ 108D-4. LME/MCO enrollee grievance and appeal procedures, generally.

(a) Each LME/MCO shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees, and network providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.

(b) Enrollees, or network providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. An oral filing must be followed by a written, signed grievance or appeal unless the enrollee or network provider requests an expedited appeal.

(c) An LME/MCO shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an LME/MCO level appeal, or a request for a contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or network providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) An LME/MCO shall not take punitive action against a network provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

- 1 (2) Requesting an LME/MCO level appeal on behalf of an enrollee or
2 supporting an enrollee's request for an LME/MCO level appeal.
3 (3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or
4 supporting an enrollee's request for an LME/MCO level expedited appeal.
5 (4) Requesting a contested case hearing on behalf of an enrollee or supporting
6 an enrollee's request for a contested case hearing.

7 **"§ 108D-5. LME/MCO enrollee grievances.**

8 (a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to
9 act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to
10 express dissatisfaction about any matter other than a managed care action. Upon receipt of a
11 grievance, an LME/MCO shall acknowledge receipt of the grievance in writing by United
12 States mail.

13 (b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance as
14 expeditiously as the enrollee's health condition requires, but no later than 90 days after receipt
15 of the grievance. The LME/MCO shall provide the enrollee and all other affected parties with
16 written notice of the grievance disposition by United States mail within this 90-day period.

17 (c) No Appeal of a Grievance Disposition. – An enrollee, or a network provider
18 authorized in writing to act on behalf of an enrollee, receiving a grievance disposition has no
19 right to the administrative appeal procedures described in G.S. 108D-6, G.S. 108D-7 and G.S.
20 108D-8.

21 **"§ 108D-6. Standard LME/MCO enrollee level appeals.**

22 (a) Notice of Managed Care Action. – An LME/MCO shall provide an enrollee with
23 written notice of a managed care action by United States mail in a manner consistent with 42
24 C.F.R. Part 438, Subpart F.

25 (b) Request for Appeal. – An enrollee, or a network provider authorized in writing to
26 act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a
27 notice of managed care action no later than 30 days after the mailing date of the notice of
28 managed care action. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO
29 shall acknowledge receipt of the request for appeal in writing by United States mail.

30 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
31 during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R.
32 § 438.420.

33 (d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as
34 the enrollee's health condition requires, but no later than 45 days after receiving the request for
35 appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written
36 notice of resolution by United States mail within this 45-day period.

37 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
38 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
39 hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the
40 appeal procedures described in G.S. 108D-6 or G.S. 108D-7, if applicable.

41 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
42 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
43 contested case hearing that meets the requirements of G.S. 108D-8(e).

44 **"§ 108D-7. Expedited LME/MCO enrollee level appeals.**

45 (a) Request for Expedited Appeal. – When the time limits for completing a standard
46 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or
47 regain maximum function, an enrollee, or a network provider authorized in writing to act on
48 behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care
49 action no later than 30 days after the mailing date of the notice of managed care action. For
50 expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee

1 qualifies for an expedited appeal. For expedited appeal requests made by network providers on
2 behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

3 (b) Notice of Denial for Expedited Appeal. – If the LME/MCO denies a request for an
4 expedited LME/MCO level appeal, the LME/MCO shall make reasonable efforts to give the
5 enrollee and all other affected parties oral notice of the denial and follow up with written notice
6 of denial by United States mail by no later than two calendar days after receiving the request
7 for an expedited appeal. In addition, the LME/MCO shall resolve the appeal within the time
8 limits established for standard LME/MCO level appeals in G.S. 108D-6.

9 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
10 during the pendency of an expedited LME/MCO level appeal to the extent required under 42
11 C.F.R. § 438.420.

12 (d) Notice of Resolution. – If the LME/MCO grants a request for an expedited
13 LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the
14 enrollee's health condition requires and no later than three working days after receiving the
15 request for an expedited appeal. The LME/MCO shall provide the enrollee and all other
16 affected parties with a written notice of resolution by United States mail within this three-day
17 period.

18 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
19 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
20 hearing pursuant to G.S. 108D-8 as long as the enrollee, or network provider, has exhausted the
21 appeal procedures described in G.S. 108D-6 or G.S. 108D-7.

22 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
23 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
24 contested case hearing that meets the requirements of G.S. 108D-8(e).

25 **"§ 108D-8. Contested case hearings on disputed managed care actions.**

26 (a) Jurisdiction of OAH. – The Office of Administrative Hearings does not have
27 jurisdiction over a dispute concerning a grievance. The Office of Administrative Hearings does
28 not have jurisdiction over a dispute involving a managed care action, except as expressly set
29 forth in this Chapter.

30 (b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or
31 rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of
32 resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not
33 apply to enrollees contesting a managed care action.

34 (c) Request for Contested Case Hearing. – A request for an administrative hearing to
35 appeal a notice of resolution issued by an LME/MCO is a contested case subject to the
36 provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or a network
37 provider authorized in writing to act on behalf of an enrollee, has the right to file a request for
38 appeal to contest a notice of resolution as long as the enrollee or network provider has
39 exhausted the appeal procedures described in G.S. 108D-6 or G.S. 108D-7, if applicable.

40 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act
41 on behalf of an enrollee, may appeal a notice of resolution by filing an appeal request form that
42 meets the requirements of subsection (e) of this section at OAH and sending a copy of the filing
43 to the affected LME/MCO by no later than 30 days after the mailing date of the notice of
44 resolution. A request for appeal is deemed filed when a completed and signed appeal request
45 form has been both submitted into the care and custody of the chief hearings clerk of OAH and
46 accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form,
47 information contained in the notice of resolution is no longer confidential, and the LME/MCO
48 shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may
49 dispose of these records after one year.

50 (e) Appeal Request Form. – In the same mailing as the notice of resolution, the
51 LME/MCO shall also provide the enrollee with an appeal request form for a contested case

1 hearing which shall be no more than one side of one page. The form shall include at least all of
2 the following:

- 3 (1) A statement that in order to request an appeal, the enrollee must file the form
4 by mail or fax at the address or fax number listed on the form by no later
5 than 30 days after the mailing date of the notice of resolution.
- 6 (2) The enrollee's name, address, telephone number, and Medicaid identification
7 number.
- 8 (3) A preprinted statement that indicates that the enrollee would like to appeal a
9 specific managed care action identified in the notice of resolution.
- 10 (4) A statement informing the enrollee of the right to be represented at the
11 contested case hearing by a lawyer, a relative, a friend, or other
12 spokesperson.
- 13 (5) A space for the enrollee's signature and date.

14 (f) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
15 during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420.
16 Notwithstanding any other provision of State law, the administrative law judge does not have
17 the power to order and shall not order an LME/MCO to continue benefits in excess of what is
18 required by 42 C.F.R. § 438.420.

19 (g) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
20 150B of the General Statutes, the chief administrative law judge of OAH may limit and
21 simplify the administrative hearing procedures that apply to contested case hearings conducted
22 pursuant to this section in order to complete these cases as expeditiously as possible. Any
23 simplified hearing procedures approved by the chief administrative law judge pursuant to this
24 subsection must comply with all of the following requirements:

- 25 (1) OAH shall schedule and hear cases by no later than 55 days after receipt of a
26 request for a contested case hearing.
- 27 (2) OAH shall conduct all contested case hearings telephonically or by video
28 technology with all parties, unless the enrollee requests that the hearing be
29 conducted in person before the administrative law judge. An in-person
30 hearing shall be conducted in Wake County unless the enrollee's
31 impairments limit travel. For enrollees with impairments that limit travel, an
32 in-person hearing shall be conducted in the enrollee's county of residence.
33 OAH shall provide written notice to the enrollee of the use of telephonic
34 hearings, hearings by video conference, and in-person hearings before the
35 administrative law judge, as well as written instructions on how to request a
36 hearing in the enrollee's county of residence.
- 37 (3) The administrative law judge assigned to hear the case shall consider and
38 rule on all prehearing motions prior to the scheduled date for a hearing on
39 the merits.
- 40 (4) Neither an enrollee nor an LME/MCO is required to be represented by an
41 attorney at a contested case hearing. For cases in which the enrollee is not
42 represented by an attorney, the administrative law judge assigned to hear the
43 case shall make reasonable efforts to assure a fair hearing and to maintain a
44 complete record of the hearing.
- 45 (5) The administrative law judge may allow brief extensions of the time limits
46 imposed in this section only for good cause shown and to ensure that the
47 record is complete. The administrative law judge shall only grant a
48 continuance of a hearing in accordance with rules adopted by OAH for good
49 cause shown and shall not grant a continuance on the day of a hearing,
50 except for good cause shown. If an enrollee fails to make an appearance at a
51 hearing that has been properly noticed by OAH by United States mail, OAH

shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(6) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the LME/MCO in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the Department's expense and made part of the record, including all of the following:

1. A hearing involving medical issues such as a diagnosis, an examining physician's report, or a decision by a medical review team.

2. A hearing in which the administrative law judge considers it necessary to have a medical assessment other than the medical assessment performed by an individual involved in any previous level of review or decision making.

(h) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-8(e) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of a managed care action until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. Nothing in this subsection shall restrict the right to a contested case hearing.

(i) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing pursuant to this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(j) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the LME/MCO's managed care action and regardless of whether the LME/MCO had an opportunity to consider the evidence in resolving the LME/MCO level appeal. Upon the receipt of new evidence and at the request of the LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken against the enrollee, it shall immediately inform the administrative law judge of its decision.

(k) Issue for Hearing. – For each managed care action, the administrative law judge shall determine whether the LME/MCO substantially prejudiced the rights of the enrollee and whether the LME/MCO, based upon evidence at the hearing:

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

- (3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(l) To the extent that anything in this Part, Chapter 150B of the General Statutes, or any rules or policies adopted pursuant to these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Subpart F, Part 438, federal law prevails and applies to the extent of the conflict. All rules, rights, and procedures for contested case hearings concerning managed care actions shall be construed so as to be consistent with federal law and shall provide the enrollee with no lesser and no greater rights than those provided under federal law.

"§ 108D-9. Notice of final decision and right to seek judicial review.

The administrative law judge assigned to conduct a contested case hearing pursuant to G.S. 108D-8 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the LME/MCO to seek judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes."

SECTION 2. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO" means an LME that has been approved by the Department to operate the 1915(b)/(c) Medicaid Waiver."

SECTION 3. G.S. 122C-151.3 reads as rewritten:

"§ 122C-151.3. Dispute with area authorities or county programs.

(a) An area authority or county program shall establish written procedures for resolving disputes over decisions of an area authority or county program that may be appealed to the State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and shall provide an opportunity for those who dispute the decision to present their position.

(b) This section does not apply to enrollee grievances or appeals subject to Chapter 108D of the General Statutes."

SECTION 4. G.S. 122C-151.4(g) reads as rewritten:

~~"(g) This section does not apply to providers of community support services who appeal directly to the Department of Health and Human Services under the Department's community support provider appeal process.~~ enrollee grievances or appeals subject to Chapter 108D of the General Statutes."

SECTION 5. G.S. 84-2.1 reads as rewritten:

"§ 84-2.1. "Practice law" defined.

The phrase "practice law" as used in this Chapter is defined to be performing any legal service for any other person, firm or corporation, with or without compensation, specifically including the preparation or aiding in the preparation of deeds, mortgages, wills, trust instruments, inventories, accounts or reports of guardians, trustees, administrators or executors, or preparing or aiding in the preparation of any petitions or orders in any probate or court proceeding; abstracting or passing upon titles, the preparation and filing of petitions for use in any court, including administrative tribunals and other judicial or quasi-judicial bodies, or assisting by advice, counsel, or otherwise in any legal work; and to advise or give opinion upon the legal rights of any person, firm or corporation: Provided, that the above reference to particular acts which are specifically included within the definition of the phrase "practice law" shall not be construed to limit the foregoing general definition of the term, but shall be construed to include the foregoing particular acts, as well as all other acts within the general definition. The phrase "practice law" does not encompass ~~the~~ any of the following:

- (1) The writing of memoranda of understanding or other mediation summaries by mediators at community mediation centers authorized by G.S. 7A-38.5 or

1 by mediators of personnel matters for The University of North Carolina or a
2 constituent institution.

3 (2) The representation of an LME/MCO by an employee or a contractor of the
4 LME/MCO in a contested case under G.S. 108D-8."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

I

SENATE BILL 98*

Short Title:	Require Pulse Oximetry Newborn Screening.	(Public)
Sponsors:	Senators Brock, Pate, Stein (Primary Sponsors); Barefoot, D. Davis, Hise, McLaurin, and Meredith.	
Referred to:	Health Care.	

February 19, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO EXPAND THE NEWBORN SCREENING PROGRAM ESTABLISHED BY
3 THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INCLUDE
4 NEWBORN SCREENING FOR CONGENITAL HEART DISEASE UTILIZING PULSE
5 OXIMETRY, AS RECOMMENDED BY THE NORTH CAROLINA CHILD FATALITY
6 TASK FORCE.

7 Whereas, in 2010, approximately 122,300 babies were born to North Carolina
8 residents; and

9 Whereas, congenital heart defects account for 24% of infant deaths due to birth
10 defects; and

11 Whereas, more than 1,400 babies with congenital heart defects do not live to
12 celebrate their first birthday; and

13 Whereas, in the United States, approximately 4,800 babies born every year have one
14 of seven critical congenital heart defects (CCHDs); and

15 Whereas, infants with one of these CCHDs are at significant risk for death or
16 disability if not diagnosed and treated soon after birth; and

17 Whereas, newborn screening using pulse oximetry, which is a noninvasive test to
18 determine the amount of oxygen in the blood and the pulse rate, can identify some CCHDs
19 before infants even show signs of the condition; and

20 Whereas, once identified, infants with CCHDs can receive specialized care and
21 treatment by a cardiologist that could prevent death or disability early in life; and

22 Whereas, in September 2011, the Secretary of the United States Department of
23 Health and Human Services approved adding screening for CCHDs to the Recommended
24 Uniform Screening Panel upon the recommendation of the Secretary's Advisory Committee on
25 Heritable Disorders in Newborns and Children; Now, therefore,
26 The General Assembly of North Carolina enacts:

27 SECTION 1. G.S. 130A-125 reads as rewritten:

28 "§ 130A-125. Screening of newborns for metabolic and other hereditary and congenital
29 disorders.

30 (a) The Department shall establish and administer a Newborn Screening Program. The
31 program shall include, but shall not be limited to:

32 (1) Development and distribution of educational materials regarding the
33 availability and benefits of newborn screening.

34 (2) Provision of laboratory testing.



- 1 (3) Development of follow-up protocols to assure early treatment for identified
2 children, and the provision of genetic counseling and support services for the
3 families of identified children.
4 (4) Provision of necessary dietary treatment products or medications for
5 identified children as medically indicated and when not otherwise available.
6 (5) For each newborn, provision of physiological screening in each ear for the
7 presence of permanent hearing loss.
8 (6) For each newborn, provision of pulse oximetry screening to detect
9 congenital heart defects.

10 (b) The Commission shall adopt rules necessary to implement the Newborn Screening
11 Program. The rules shall include, but shall not be limited to, the conditions for which screening
12 shall be required, provided that screening shall not be required when the parents or the guardian
13 of the infant object to such screening. If the parents or guardian object to the screening, the
14 objection shall be presented in writing to the physician or other person responsible for
15 administering the test, who shall place the written objection in the infant's medical record.

16 (b1) ~~The Commission for Public Health~~ shall adopt temporary and permanent rules to
17 include newborn hearing screening and pulse oximetry screening in the Newborn Screening
18 Program established under this section.

19 (b2) The Commission's rules for pulse oximetry screening shall address at least all of the
20 following:

- 21 (1) Follow-up protocols to ensure early treatment for newborn infants diagnosed
22 with a congenital heart defect, including by means of telemedicine. As used
23 in this subsection, "telemedicine" is the use of two-way, real-time interactive
24 audio and video between places of lesser and greater medical capability or
25 expertise to provide and support health care when distance separates
26 participants who are in different geographical locations.
27 (2) A system for tracking both the process and outcomes of newborn screening
28 utilizing pulse oximetry, with linkage to the Birth Defects Monitoring
29 Program established pursuant to G.S. 130A-131.16.

30 (c) A fee of nineteen dollars (\$19.00) applies to a laboratory test performed by the State
31 Laboratory of Public Health pursuant to this section. The fee for a laboratory test is a
32 departmental receipt of the Department and shall be used to offset the cost of the Newborn
33 Screening Program."

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

GENERAL ASSEMBLY OF NORTH CAROLINA



Legislative Fiscal Note

BILL NUMBER: Senate Bill 98 (First Edition)

SHORT TITLE: Require Pulse Oximetry Newborn Screening.

SPONSOR(S): Senators Brock, Pate, and Stein

FISCAL IMPACT

Yes ()

No (X)

No Estimate Available ()

FY 2013-14

FY 2014-15

FY 2015-16

FY 2016-17

FY 2017-18

REVENUES:

EXPENDITURES:

No fiscal impact

POSITIONS

(cumulative):

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: NC DHHS Divisions of Medical Assistance and Public Health; State Health Plan

EFFECTIVE DATE: This act is effective when it becomes law

BILL SUMMARY: Amends GS 130A-125 to require the Newborn Screening Program to include a pulse oximetry screening for each newborn in order to detect congenital heart defects. Directs the Commission for Public Health to adopt temporary and permanent rules to include pulse oximetry screening in the Newborn Screening Program. Specifies issues that must be addressed by the rules governing pulse oximetry screening.

ASSUMPTIONS AND METHODOLOGY: Preliminary survey data by the NC Chapter of the American Heart Association (57 of 82 hospitals responding – survey is still in progress) indicate that more than half of North Carolina hospitals currently screen newborns using pulse oximetry. Although the UNC hospitals have not yet responded to the survey, it appears that it is current UNC policy to universally screen newborns using pulse oximetry. Any fiscal impact of the proposed legislation for the State would be due to any new training and reporting requirements in the Division of Public Health and any impact to payments by Medicaid or the State Health Plan.

Division of Public Health (DPH)

The Department of Health & Human Services (DHHS) reported that the implementation of newborn screening pulse oximetry as described in the draft legislation would have no fiscal impact on the Division of Public Health. DHHS states that it will be the responsibility of birthing hospitals and local providers to (a) ensure that the required screening is made available to all newborns; (b) ensure appropriate follow-up when a positive screen is obtained; (c) report information on positive screens to a centralized database; and (d) provide continuing education to appropriate staff to ensure proficient screening. Thus, the Division of Public Health (DPH) does not anticipate any additional costs associated with the bill.

The proposed legislation directs that the Commission for Public Health shall adopt rules for the screening and for a centralized database. It is anticipated that the proposed rulemaking can be accomplished with existing staff resources.

Division of Medical Assistance (DMA)

Screening Costs: The Division of Medical Assistance (DMA) does not anticipate new costs to Medicaid due to the screening itself. Newborn screening is reimbursed by Medicaid based on specific billing codes within the Diagnosis Related Groups (DRGs). While the proposed legislation would add an additional element to the newborn screening, Medicaid reimbursement to hospitals for the overall newborn screening would be covered within the current DRGs. Medicaid would not reimburse physicians an additional amount for either performing or interpreting pulse oximetry.

Potential Costs Due to Positive Screening Results: In North Carolina in 2011 there were 120,403 live births. Data indicates that approximately 1 in 500 newborns will have a positive screen using pulse oximetry (Dr. Alex Kemper, Duke University). The Department estimates that of the 120,000 screenings performed annually, around 170 would be false positives.

Current data indicates that follow up echocardiograms reveal that 75% of positive pulse oximetry screenings are false and show that the infant's heart is healthy. In these cases, no further screening or follow up is required. A screening that tests positive for congenital heart disease would be followed by an inpatient echocardiogram test, a test that uses sound waves to create a moving picture of the heart. The hospital charge for an echocardiogram is approximately \$60. The annual cost to perform 170 echocardiograms would be around \$7,620 (170 x \$60). A portion of the annual cost would be borne by the State Medicaid program which covers approximately 54% of infants born in the State. Thus, the Medicaid program would incur around \$4,100 annually for those cases where the initial echocardiogram indicates that the pulse oximetry results were false positives and no further follow up is necessary.

For the remaining 25% of infants (42) whose screenings results are false positive, DHHS indicates that one or more additional echocardiograms would be performed on an outpatient basis, at a cost of \$314, the outpatient rate. DHHS estimates that 63 subsequent outpatient echocardiograms would be performed for a total cost of \$19,782, of which \$10,741 would be charges for infants in

the Medicaid Program. In addition, DHHS anticipates that 22 infants would be referred for a follow up outpatient cardiology consultation at a charge of \$140 each. The total cost of the outpatient cardiology consultations for these 22 infants would be \$3,080, of which \$1,672 would be charged to the Medicaid Program.

The potential Medicaid costs due to false positive results from a pulse oximetry screening is \$16,552, as summarized in the following table. This cost is not considered significant and can be accommodated within the existing Medicaid budget, which is approximately \$14.2 billion.

False Positive Follow Up Procedures	#Procedures	Rate/Charge	Medicaid Cost
Inpatient Echocardiogram	127	\$60	\$4,138
Outpatient Echocardiogram	63	\$314	\$10,742
Outpatient Cardiology Consultation	22	\$140	\$1,672
Total	212		\$16,552

DHHS indicated that some newborns with a false positive screen for congenital heart disease have other unrelated and serious conditions that will require medical care. In addition, DHHS anticipates a higher incidence of false positives when staff is first trained, declining as staff become more experienced in performing the screening.

State Health Plan

The Fiscal Research Division has not obtained an actuarial note for the impact on the State Health Plan. However, as there are approximately 6,000 deliveries covered by the State Health Plan each year, and many of these are at hospitals that already provide the screening, the impact is not anticipated to be significant.

SOURCES OF DATA: DHHS Division of Medical Assistance; Dr. Alex Kemper, Duke University; NC Chapter of American Heart Association; Carl Seashore, MD, Newborn Screening in North Carolina, UNC Department of Pediatrics, March 2012.

TECHNICAL CONSIDERATIONS: none

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Denise Thomas

APPROVED BY: Mark Trogon, Director
Fiscal Research Division

DATE: April 9, 2013



Signed Copy Located in the NCGA Principal Clerk's Offices

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

4/10/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Samuel Tchwenko	Heart Disease and Stroke Prevention Branch, Division of Public Health
Arita Holmes	Justus Warren Heart Disease & Stroke Prevention Task Force
Peg O'Connell	March of Dimes
Scott Herrick	Alzheimer's Association Greensboro NC
Eileen Vaillancourt	Alzheimer's Association
Jennifer Rosen	Alzheimer's Association
ERIC & GRACE SANUZZI	108 Rozelle Valley Ln Cary NC 27519
Joyce Mullis	2247 Plum Frost Dr. Raleigh NC 27603
Chuck Stone	SEPA
Peter J. Davis	NCPS
P. Hudgins	CFTF
Sarah Wolfe	MWC LLC
April Lee	NCPHX
Pam Seaman	NC Alliance for Health
Tommy Lee	MWC
Edith Davis	ED&A
Carolina Inn	Carolina Inn

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

4/10/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Amy Whited	NCMS
Joe Donovan	SCNC
Kerren Baiter	LCA
E. Nelson	NCHA
DANIEL VANLIERE	VIOANT HEALTH
Cory HAND	NCHA
Ken Melch	Benchmark
Annaliese Dulpn	Dolph Law
Sally Cameron	NC Psychological
Inf...	Bon...
Deborah Dyl...	KLG
Alan Miller	KLG
Andy Chase	KMA
George Smith	NA
Mari Wild...	Norant Health
John Del Grosso	Brubaker + Assoc.
Wendy King	Rising Group

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

4/10/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Allison Waller	Nelson Mullins
Christine Craig	WakeMed
Rob Hamme	RLA
TRACY COLVARD	STATE

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

(Committee Name)

4/10/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
JEFF BARNHART	MWLC
Julian Mann	DAH
Adam Sholar	DHHS
Joel Maynard	NCAFP
Phil L. Plam	TCF

Senate Committee on Health Care
Wednesday, April 17, 2013 at 11:00 AM
Room 544 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 11:00 AM on April 17, 2013 in Room 544 of the Legislative Office Building. Eighteen members were present.

Senator Louis Pate, Chair, presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms for the meeting: Billy Fritchner, Ed Kessler, Ashley Mickens, and Steve Wilson. He also recognized the following Pages assisting with the meeting: Maranola Judd and Treston Garrington, both of Holly Springs, Candace Brown of Raleigh and Karen Metts of Trenton.

Senator Parmon was recognized to explain SB 687 "Involuntary Commitment Custody Orders." A PCS was offered with Sen. Barefoot making a motion to adopt the PCS for discussion. Senator Robinson made a motion for the PCS to receive a Favorable Report, Unfavorable to Original Bill with referral to J-1 Committee. The motion carried.

Senator Pate then recognized Senator Hartsell to explain SB 248, "Choice of Hearing Aid Specialist." Senator Randleman make a motion for adoption of the PCS for discussion. After much discussion, Sen. Hise moved for a Favorable Report of the PCS, Unfavorable as to Original Bill, with referral to Finance. Motion carried.

Senator Jim Davis was asked to explain SB 594 "Require Drug Testing/Work First Benefits." After explaining the bill, Senator Davis entertained numerous questions. An amendment was made by Senator Parmon to be rolled into a PCS. Senator Hise moved that the bill receive a Favorable Report as Amended. The motion carried.

The meeting adjourned at 11:58 a.m.


Senator Louis Pate, Chair
Presiding


Edna Pearce, Committee Clerk

Principal Clerk
Reading Clerk

Corrected #1: Addition of SB594

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 17, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 248	Choice of Hearing Aid Specialist.	Senator Hartsell
SB 687	Involuntary Commitment Custody Orders.	Senator Parmon
SB 594	Require Drug Testing/Work First Benefits.	Senator Brunstetter
		Senator J. Davis

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, April 17, 2013

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

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

SB 248 Choice of Hearing Aid Specialist.
Draft Number: S248-PCS15252-MEf-10
Sequential Referral: None
Recommended Referral: Finance
Long Title Amended: Yes

SB 687 Involuntary Commitment Custody Orders.
Draft Number: S687-PCS35326-RF-8
Sequential Referral: Judiciary I
Recommended Referral: None
Long Title Amended: No

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

SB 594 (CS#1) Require Drug Testing/Work First Benefits.
Draft Number: S594-PCS35324-TK-14
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Senator Fletcher Hartsell will handle SB 248
Senator Earline Parmon will handle SB 687
Senator James Davis will handle SB 594



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 248

Short Title: Choice of Hearing Aid Specialist. (Public)

Sponsors: Senators Hartsell (Primary Sponsor); and J. Davis.

Referred to: Health Care.

March 12, 2013

A BILL TO BE ENTITLED
AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR
HEARING AID SPECIALIST UNDER THEIR HEALTH BENEFIT PLANS AND TO
AUTHORIZE THE NORTH CAROLINA STATE HEARING AID DEALERS AND
FITTERS BOARD TO INCREASE CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30 reads as rewritten:

"§ 58-50-30. Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, chiropractor, hearing aid specialist, physical therapist, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed hearing aid specialist, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the



policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed hearing aid specialist, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(c5) For purposes of this section, a "duly licensed physical therapist" is a person licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.

(c6) For purposes of this section, a "duly licensed hearing aid specialist" is a person licensed by the North Carolina State Hearing Aid Dealers and Fitters Board pursuant to Chapter 93D of the General Statutes.

...."
SECTION 2. G.S. 93D-5 reads as rewritten:

"§ 93D-5. Requirements for registration; examinations; licenses.

(a) No person shall begin the fitting and selling of hearing aids in this State unless the person has been issued a license by the Board or is an apprentice working under the supervision of a Registered Sponsor. Except as hereinafter provided, each applicant for a license shall pay a fee set by the Board, not to exceed ~~two hundred fifty dollars (\$250.00)~~, five hundred dollars (\$500.00), which fee may be prorated by the Board, and shall show to the satisfaction of the Board that the applicant:

- (1) Is a person of good moral character.
- (2) Is 18 years of age or older.
- (3) Has an education equivalent to a four-year course in an accredited high school.

...."
SECTION 3. G.S. 135-48.51(12) reads as rewritten:

"(12) G.S. 58-50-30, Right to choose services of optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, hearing aid specialist, physical therapist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant."

SECTION 4. This act becomes effective October 1, 2012.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 248
PROPOSED COMMITTEE SUBSTITUTE S248-CSMEf-10 [v.4]

4/16/2013 2:05:22 PM

Short Title: Choice of Hearing Aid Specialist.

(Public)

Sponsors:

Referred to:

March 12, 2013

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR
HEARING AID SPECIALIST UNDER THEIR HEALTH BENEFIT PLANS, TO
AUTHORIZE THE NORTH CAROLINA STATE HEARING AID DEALERS AND
FITTERS BOARD TO INCREASE CERTAIN FEES, AND TO MAKE TECHNICAL
CHANGES TO THE STATUTE ON CHOOSING SERVICES OF PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30 reads as rewritten:

"§ 58-50-30. Right to choose services of ~~optometrist, podiatrist, licensed clinical social
worker, certified substance abuse professional, licensed professional counselor,
dentist, chiropractor, physical therapist, psychologist, pharmacist, certified
fee-based practicing pastoral counselor, advanced practice nurse, licensed
marriage and family therapist, or physician assistant.~~ certain providers.

(a) Repealed by Session Laws 2001-297, s. 1, effective January 1, 2001.

(a1) Whenever any health benefit plan, subscriber contract, or policy of insurance issued
by a health maintenance organization, hospital or medical service corporation, or insurer.
governed by Articles 1 through 67 of this Chapter provides for coverage for, payment of, or
reimbursement for any service rendered in connection with a condition or complaint that is
within the scope of practice of ~~a duly licensed optometrist, a duly licensed podiatrist, a duly
licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed
clinical social worker, a duly certified substance abuse professional, a duly licensed
professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly
certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly
licensed marriage and family therapist, or an advanced practice registered nurse, a provider
listed in subsection (b) of this section~~ the insured or other persons entitled to benefits under the
policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether
the services be performed by a duly licensed physician, or a provider listed in ~~this subsection,
subsection (b) of this section,~~ notwithstanding any provision contained in the plan or policy
limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to
choose the provider of services notwithstanding any provision to the contrary in any other
statute, subject to the utilization review, referral, and prior approval requirements of the plan
that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition
of obtaining benefits under the plan or policy, the policyholder, insured, or
beneficiary must choose a provider of the services within the network; and



(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

(a2) Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of ~~a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, a duly licensed marriage and family therapist, or an advanced practice registered nurse,~~ a provider listed in subsection (b) of this section, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, or a provider listed in ~~this subsection,~~ subsection (b) of this section, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute; provided that for plans that require the use of network providers either as a condition of obtaining benefits under the plan or policy or to access a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network, subject to the requirements of the plan or policy.

(a3) Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) ~~For the purposes of this section,~~ This section applies to the following provider types:

(1) A duly licensed optometrist.

(2) A duly licensed dentist.

(3) A duly licensed podiatrist.

(4) A duly licensed chiropractor.

(5) An advanced practice registered nurse, subject to subsection (d) of this section. For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(6) ~~a "duly licensed psychologist" is a:~~ A psychologist who is one of the following:

(1)a. ~~Licensed~~ A licensed psychologist who holds permanent licensure and certification as a health services provider psychologist issued by the North Carolina Psychology Board; ~~or Board.~~

(2)b. ~~Licensed~~ A licensed psychological associate who holds permanent licensure.

(e)(7) ~~For the purposes of this section, a "duly licensed clinical social worker" is a "licensed clinical social worker"~~ A licensed clinical social worker, as defined in G.S. 90B-3(2) and G.S. 90B-3(2) who is licensed by the North Carolina Social Work Certification and Licensure Board pursuant to Chapter 90B of the General Statutes.

(8) A duly licensed pharmacist, subject to the provisions of subsection (e) of this section.

~~(e1)(9) For purposes of this section, a "duly certified fee-based practicing pastoral counselor" shall be defined only to include A fee-based practicing pastoral counselors counselor certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.~~

~~(e2)(10) For purposes of this section, a "duly certified substance abuse professional" is a person A substance abuse professional certified by the North Carolina Substance Abuse Professional Certification Board pursuant to Article 5C of Chapter 90 of the General Statutes.~~

(11) A physician assistant, as defined by G.S. 90-18.1 and subject to subsection (f) of this section.

~~(e3)(12) For purposes of this section, a "duly licensed professional counselor" is a person A professional counselor licensed by the North Carolina Board of Licensed Professional Counselors pursuant to Article 24 of Chapter 90 of the General Statutes.~~

~~(e4)(13) For purposes of this section, a "duly licensed marriage and family therapist" is a person A marriage and family therapist licensed by the North Carolina Marriage and Family Therapy Licensure Board pursuant to Article 18C of Chapter 90 of the General Statutes.~~

~~(e5)(14) For purposes of this section, a "duly licensed physical therapist" is a person A physical therapist licensed by the North Carolina Board of Physical Therapy Examiners pursuant to Article 18B of Chapter 90 of the General Statutes.~~

(15) A hearing aid specialist licensed by the North Carolina State Hearing Aid Dealers and Fitters Board pursuant to Chapter 93D of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

- (1) The service performed is within the nurse's lawful scope of practice;
- (2) The policy currently provides benefits for identical services performed by other licensed health care providers;
- (3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;
- (4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and
- (5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision, unless these plan requirements apply to all providers for that service.

~~For purposes of this section, an "advanced practice registered nurse" means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.~~

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

- (1) The service performed is within the lawful scope of practice of the pharmacist;
- (2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

- (3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
- (4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

- (1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;
- (2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
- (3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. ~~For the purposes of this section, a "duly licensed physician assistant" is a physician assistant as defined by G.S. 90-18.1.~~

(g) A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network or from eligibility to provide particular covered services under the plan or policy any duly licensed physician or provider listed in subsection ~~(a1)~~ (b) of this section, acting within the scope of the provider's license or certification under North Carolina law, solely on the basis of the provider's license or certification. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that offers coverage through a network plan may condition participation in the network on satisfying written participation criteria, including credentialing, quality, and accessibility criteria. The participation criteria shall be developed and applied in a like manner consistent with the licensure and scope of practice for each type of provider. Any health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter that excludes a provider listed in subsection ~~(a1)~~ (b) of this section from participation in its network or from eligibility to provide particular covered services under the plan or policy shall provide the affected listed provider with a written explanation of the basis for its decision. A health maintenance organization, hospital or medical service corporation, or insurer governed by Articles 1 through 67 of this Chapter shall not exclude from participation in its provider network a provider listed in subsection ~~(a1)~~ (b) of this section acting within the scope of the provider's license or certification under North Carolina law solely on the basis that the provider lacks hospital privileges, unless use of hospital services by the provider on behalf of a policy holder, insured, or beneficiary reasonably could be expected.

(h) Nothing in this section shall be construed as expanding the scope of practice of any duly licensed physician or provider listed in subsection ~~(a1)~~ (b) of this section."

SECTION 2. G.S. 93D-5 reads as rewritten:

"§ 93D-5. Requirements for registration; examinations; licenses.

(a) No person shall begin the fitting and selling of hearing aids in this State unless the person has been issued a license by the Board or is an apprentice working under the supervision of a Registered Sponsor. Except as hereinafter provided, each applicant for a license shall pay a fee set by the Board, not to exceed ~~two hundred fifty dollars (\$250.00)~~, five hundred dollars (\$500.00), which fee may be prorated by the Board, and shall show to the satisfaction of the Board that the applicant:

- (1) Is a person of good moral character.
- (2) Is 18 years of age or older.
- (3) Has an education equivalent to a four-year course in an accredited high school.

...."

SECTION 3. G.S. 135-48.51(12) reads as rewritten:

"(12) G.S. 58-50-30, Right to choose services of ~~optometrist, podiatrist, licensed clinical social worker, certified substance abuse professional, licensed professional counselor, dentist, physical therapist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, advanced practice nurse, licensed marriage and family therapist, or physician assistant.~~ certain providers."

SECTION 4. This act becomes effective October 1, 2013.



SENATE BILL 248: Choice of Hearing Aid Specialist

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Hartsell
Analysis of: PCS to First Edition
S248-CSMEf-10

Date: April 11, 2013
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 656 adds hearing aid specialists to the list of providers from which an individual has the right to choose the provider of services under a health benefit plan. The bill also increases the amount of the fee for licensure that the Board may assess from \$250 to \$500.*

The Proposed Committee Substitute corrects the effective date and makes technical changes to the statute.

CURRENT LAW:

G.S. 58-50-30 lists the various types of health care providers from which a policy holder, insured, or beneficiary ("insured") may choose under a health benefit plan, subscriber contract, or policy of insurance ("policy"). The services must be of a nature that the policy provides coverage of, or payment or reimbursement. If the policy requires use of network providers, the insured must choose a provider of services within the network. If the policy requires use of network providers as a condition of obtaining a higher level of benefits, the insured must choose a provider of services within network in order to obtain the higher level of benefits.

G.S. 58-50-30 also lists the provider types who are able to complete a certification of disability. When a policy provides for a certification of disability that is within the scope of the enumerated providers, the insured is entitled to benefits as long as one of the listed provider types has completed the certification of disability, notwithstanding any provisions contained in the policy. The insured has the right to choose the provider of services.

The provisions of G.S. 58-50-30 are applicable to the State Health Plan pursuant to G.S. 135-48.51.

BILL ANALYSIS:

Section 1 of Senate Bill 656 amends G.S. 58-50-30 to add "a duly licensed hearing aid specialist" to the list of health care providers from which an insured may choose under a policy. A "duly licensed hearing aid specialist" is defined as a person licensed by the North Carolina State Hearing Aid Dealers and Fitters Board (Board) pursuant to Chapter 93D of the General Statutes. The remainder of Section 1 contains technical changes meant increase the readability of the statute by reorganizing the list of providers accounted for under G.S. 58-50-30.

Section 2 changes the amount of the fee for licensure the (Board) may assess. Currently, the Board may assess a fee not to exceed \$250. Under Senate Bill 248, that amount is increased to \$500.

Section 3 makes a conforming change to G.S. 135-48.51(12), the statute applying G.S. 58-50-30 to the State Health Plan.

EFFECTIVE DATE: The act becomes effective October 1, 2013.



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 687

Short Title:	Involuntary Commitment Custody Orders.	(Public)
Sponsors:	Senators Parmon and Brunstetter (Primary Sponsors).	
Referred to:	Health Care.	

April 4, 2013

A BILL TO BE ENTITLED
AN ACT ALLOWING A CLERK OR ASSISTANT OR DEPUTY CLERK OF SUPERIOR COURT OR A MAGISTRATE TO ISSUE BY FACSIMILE TRANSMISSION AN INVOLUNTARY INPATIENT COMMITMENT CUSTODY ORDER TO A PETITIONING PHYSICIAN, ELIGIBLE PSYCHOLOGIST, OR DESIGNEE AT A TWENTY-FOUR-HOUR FACILITY WHEN THE RESPONDENT IS ALREADY PHYSICALLY PRESENT AT THE TWENTY-FOUR-HOUR FACILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-261(d) reads as rewritten:

"(d) If the affiant is a physician or eligible psychologist, the all of the following apply:

(1) The affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit or a copy in paper form that is printed through the facsimile transmission of the affidavit. If the affidavit is filed through facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit.

(2) This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c).

(3) If the physician or eligible psychologist recommends outpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician or eligible psychologist shall contact the local management entity that serves the county where the respondent resides or the local management entity that coordinated services for the respondent to inform the local management entity that the respondent has been scheduled for an appointment with an outpatient treatment physician or center.

(4) If the physician or eligible psychologist recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the



* S 6 8 7 - V - 1 *

respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transportation to or custody at a 24-hour facility described in G.S. 122C-252, provided that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2).

- (5) If the affiant is a physician or eligible psychologist at a 24-hour facility described in G.S. 122C-252 who recommends inpatient commitment; the respondent is physically present on the premises of the same 24-hour facility; and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the clerk or magistrate may issue by facsimile transmission an order to the physician or eligible psychologist at the 24-hour facility, or a designee, to take the respondent into custody at the 24-hour facility and proceed according to G.S. 122C-266. Upon receipt of the custody order, the physician or eligible psychologist at the 24-hour facility, or a designee, shall immediately (i) notify the respondent that the respondent is not under arrest and has not committed a crime but is being taken into custody to receive treatment and for the respondent's own safety and the safety of others, (ii) take the respondent into custody, and (iii) complete and sign the appropriate portion of the custody order and return the order to the clerk or magistrate by facsimile transmission. The physician or eligible psychologist, or a designee, shall mail the original custody order no later than five days after transmitting it by facsimile to the clerk or magistrate. The clerk or magistrate shall file the original custody order with the facsimile copy of the custody order. Notwithstanding the provisions of this subdivision, a clerk or magistrate shall not issue a custody order to a physician or eligible psychologist at a 24-hour facility, or a designee, who has not completed training in proper service and return of service. As used in this subdivision, the term "designee" includes the 24-hour facility's on-site police security personnel.
- (6) If the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported.
- (7) If a physician or eligible psychologist executes an affidavit for inpatient commitment of a respondent, a second physician shall be required to perform the examination required by G.S. 122C-266."

SECTION 2. G.S. 122C-261(e) reads as rewritten:

"(e) ~~Upon~~ Except as provided in subsection (d) of this section, upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State."

SECTION 3. This act becomes effective October 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 687
PROPOSED COMMITTEE SUBSTITUTE S687-CSRF-8 [v.1]
4/16/2013 4:57:54 PM

Short Title: Involuntary Commitment Custody Orders.

(Public)

Sponsors:

Referred to:

April 4, 2013

1 A BILL TO BE ENTITLED
2 AN ACT ALLOWING A CLERK OR ASSISTANT OR DEPUTY CLERK OF SUPERIOR
3 COURT OR A MAGISTRATE TO ISSUE BY FACSIMILE TRANSMISSION AN
4 INVOLUNTARY INPATIENT COMMITMENT CUSTODY ORDER TO A
5 PETITIONING PHYSICIAN, ELIGIBLE PSYCHOLOGIST, OR DESIGNEE AT A
6 TWENTY-FOUR-HOUR FACILITY WHEN THE RESPONDENT IS ALREADY
7 PHYSICALLY PRESENT AT THE TWENTY-FOUR-HOUR FACILITY.

8 The General Assembly of North Carolina enacts:

9 SECTION 1. G.S. 122C-261(d) reads as rewritten:

10 "(d) If the affiant is a physician or eligible psychologist, the all of the following apply:

11 (1) The affiant may execute the affidavit before any official authorized to
12 administer oaths. This affiant is not required to appear before the clerk or
13 magistrate for this purpose. This affiant shall file the affidavit with the clerk
14 or magistrate by delivering to the clerk or magistrate the original affidavit or
15 a copy in paper form that is printed through the facsimile transmission of the
16 affidavit. If the affidavit is filed through facsimile transmission, the affiant
17 shall mail the original affidavit no later than five days after the facsimile
18 transmission of the affidavit to the clerk or magistrate to be filed by the clerk
19 or magistrate with the facsimile copy of the affidavit.

20 (2) This affiant's examination shall comply with the requirements of the initial
21 examination as provided in G.S. 122C-263(c).

22 (3) If the physician or eligible psychologist recommends outpatient commitment
23 and the clerk or magistrate finds probable cause to believe that the
24 respondent meets the criteria for outpatient commitment, the clerk or
25 magistrate shall issue an order that a hearing before a district court judge be
26 held to determine whether the respondent will be involuntarily committed.
27 The physician or eligible psychologist shall provide the respondent with
28 written notice of any scheduled appointment and the name, address, and
29 telephone number of the proposed outpatient treatment physician or center.
30 The physician or eligible psychologist shall contact the local management
31 entity that serves the county where the respondent resides or the local
32 management entity that coordinated services for the respondent to inform the
33 local management entity that the respondent has been scheduled for an
34 appointment with an outpatient treatment physician or center.

35 (4) If the physician or eligible psychologist recommends inpatient commitment
36 and the clerk or magistrate finds probable cause to believe that the



* S 6 8 7 - C S R F - 8 - V - 1 *

respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transportation to or custody at a 24-hour facility described in G.S. 122C-252, provided that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2).

(5) If the affiant is a physician or eligible psychologist at a 24-hour facility described in G.S. 122C-252 who recommends inpatient commitment; the respondent is physically present on the premises of the same 24-hour facility; and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the clerk or magistrate may issue by facsimile transmission an order to the physician or eligible psychologist at the 24-hour facility, or a designee, to take the respondent into custody at the 24-hour facility and proceed according to G.S. 122C-266. Upon receipt of the custody order, the physician or eligible psychologist at the 24-hour facility, or a designee, shall immediately (i) notify the respondent that the respondent is not under arrest and has not committed a crime but is being taken into custody to receive treatment and for the respondent's own safety and the safety of others, (ii) take the respondent into custody, and (iii) complete and sign the appropriate portion of the custody order and return the order to the clerk or magistrate by facsimile transmission. The physician or eligible psychologist, or a designee, shall mail the original custody order no later than five days after transmitting it by facsimile to the clerk or magistrate. The clerk or magistrate shall file the original custody order with the facsimile copy of the custody order. Notwithstanding the provisions of this subdivision, a clerk or magistrate shall not issue a custody order to physician or eligible psychologist at a 24-hour facility, or a designee, if the physician or eligible psychologist, or a designee, has not completed training in proper service and return of service. As used in this subdivision, the term "designee" includes the 24-hour facility's on-site police security personnel.

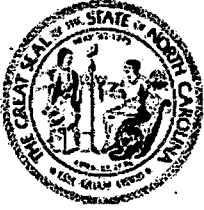
(6) If the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported.

(7) If a physician or eligible psychologist executes an affidavit for inpatient commitment of a respondent, a second physician shall be required to perform the examination required by G.S. 122C-266."

SECTION 2. G.S. 122C-261(e) reads as rewritten:

"(e) Upon Except as provided in subsection (d) of this section, upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State."

SECTION 3. This act becomes effective October 1, 2013.



SENATE BILL 687: Involuntary Commitment Custody Orders

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Judiciary I	Date:	April 16, 2013
Introduced by:	Sens. Parmon, Brunstetter	Prepared by:	Barbara Riley
Analysis of:	PCS to First Edition S687-CSRF-8		Committee Counsel

SUMMARY: *Senate Bill 687 would authorize a clerk or a magistrate to issue an involuntary inpatient commitment custody order by means of facsimile transmission when a respondent is already at a twenty-four hour facility. The PCS makes a technical change to the original bill.*

[As introduced, this bill was identical to H635, as introduced by Reps. Lambeth, Conrad, Terry, Hanes, which is currently in House Judiciary Subcommittee C.]

CURRENT LAW: G.S. 122C-261 provides for the affidavit and petition to the magistrate, or clerk or deputy or assistant clerk of superior court, by anyone with knowledge that a person is mentally ill, and either dangerous to self or others, or in need of treatment in order to prevent further deterioration that would result in dangerousness. A magistrate or clerk finding reasonable grounds to believe that the allegations are true shall order the person taken into custody for examination.

Subsection (d) of G.S. 122C-261 provides that if the person filing the affidavit is a physician or eligible psychologist, the affiant is not required to appear before the clerk or magistrate but may execute the affidavit before any official authorized to administer oaths which may be faxed to the clerk or magistrate. If the physician recommends inpatient treatment, and the clerk or magistrate finds reasonable cause to believe the respondent meets the criteria for inpatient commitment, an order for transportation to a 24 hour facility shall be ordered.

BILL ANALYSIS: Section 1 of Senate Bill 687 would add a new subsection (5) to G.S. 122C-261(d) to provide that if a person is physically present at a 24-hour facility and a physician or psychologist at the facility recommends that the person be involuntarily committed, then a clerk or magistrate finding probable cause to believe the person meets the commitment criteria may transmit the custody order to the physician or psychologist, or a designee, by means of facsimile. The term "designee" includes the facility's on-site security personnel.

Upon receiving the custody order, the physician, psychologist or designee is required to do the following:

- Notify the respondent that the respondent has neither committed a crime nor is under arrest, but is being taken into custody for safety and treatment reasons.
- Take the respondent into custody.
- Complete and sign the custody order and return it to the clerk or magistrate via facsimile.
- Mail the original custody order to the clerk or magistrate within five days of the facsimile transmission.



Senate PCS 687

Page 2

The clerk or magistrate must file the original custody order with the facsimile copy. A clerk or magistrate shall not issue a custody order to a physician, eligible psychologist, or designee at a 24 hour facility who has not completed training in proper service and return of service.

Section 2 amends G.S. 122C-261(e) to provide an exception to the provision requiring a law enforcement officer or other person to take a person into custody when that person is already in custody at the 24-hour facility.

EFFECTIVE DATE: This act would become effective October 1, 2013.

Jan Paul, counsel to House Judiciary C, substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

2

SENATE BILL 594
Judiciary II Committee Substitute Adopted 4/10/13

Short Title: Require Drug Testing/Work First Benefits.

(Public)

Sponsors:

Referred to:

April 4, 2013

A BILL TO BE ENTITLED
AN ACT TO REQUIRE DRUG SCREENING FOR APPLICANTS FOR AND RECIPIENTS
OF WORK FIRST PROGRAM ASSISTANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-29.1 reads as rewritten:

"§ 108A-29.1. Substance abuse treatment required; drug testing required for Work First Program applicants and recipients.

(a) ~~Each applicant or current recipient of Work First Program benefits, determined by a Qualified Professional in Substance Abuse (QPSA) or by a physician certified by the American Society of Addiction Medicine (ASAM) to be addicted to alcohol or drugs and to be in need of professional substance abuse treatment services shall be required, as part of the person's MRA and as a condition to receiving Work First Program benefits, to participate satisfactorily in an individualized plan of treatment in an appropriate treatment program. As a mandatory program component of participation in an addiction treatment program, each applicant or current recipient shall be required to submit to an approved, reliable, and professionally administered regimen of testing for presence of alcohol or drugs, without advance notice, during and after participation, in accordance with the addiction treatment program's individualized plan of treatment, follow up, and continuing care services for the applicant or current recipient. The Department shall require a drug test to screen each applicant for or recipient of Work First Program assistance. The cost of the drug testing is the responsibility of the individual tested. The Department shall provide notice of drug testing to each applicant or recipient. The notice shall advise the applicant or recipient that drug testing will be conducted as a condition of receiving Work First Program assistance, and that the results of the drug tests will remain confidential and will not be released to law enforcement. The applicant or recipient shall be advised that the required drug testing may be avoided if the applicant or recipient does not apply for Work First Program assistance. Dependent children under the age of 18 are exempt from the requirements of this section. The Department shall require the following:~~

- (1) That for two-parent families, both parents comply with the drug-testing requirement.
- (2) That any teen parent who is emancipated pursuant to Article 35 of Chapter 7B of the General Statutes comply with the drug-testing requirement.
- (3) That each applicant or recipient be advised before testing that he or she may inform the agent administering the test of any prescription or over-the-counter medication he or she is taking.



(4) That each applicant or recipient being tested to sign a written acknowledgement that he or she has received and understood the notice and advice provided under this subsection.

(5) That each applicant or recipient who fails a drug test understands that he or she has the right to take one or more additional tests.

(b) ~~An applicant or current recipient who fails to comply with any requirement imposed pursuant to this section shall not be eligible for benefits or shall be subject to the termination of benefits, but shall be considered to be receiving benefits for purposes of determining eligibility for medical assistance.~~ For an applicant or current recipient who tests negative for controlled substances, the Department shall increase the amount of the initial Work First Program assistance by the amount paid by the applicant or recipient for the drug testing. An applicant or recipient who tests positive for controlled substances as a result of a drug test required under this section is ineligible to receive Work First Program assistance for one year from the date of the positive drug test except as provided in subsection (b1) of this section. The individual may reapply after one year. However, if the individual has any subsequent positive drug tests, the individual shall be ineligible for benefits for three years from the date of the subsequent positive drug test unless the individual reapplies pursuant to subsection (b1) of this section.

(b1) An applicant or recipient deemed ineligible may reapply for Work First Program assistance if the individual can document the successful completion of a substance abuse treatment program offered by a provider under subsection (e) of this section and licensed by the Department. The applicant or recipient who reapplies for Work First Program assistance after completion of a substance abuse program shall pass a drug test. The cost of any drug testing and substance abuse program provided under this subsection shall be the responsibility of the applicant or recipient being tested and receiving treatment. An applicant or recipient who reapplies for Work First Program assistance pursuant to this subsection may reapply one time only.

(c) The children of any applicant or current recipient shall remain eligible for benefits, and these benefits shall be paid to a protective payee pursuant to G.S. 108A-38.

(d) ~~An applicant or current recipient shall not be regarded as failing to comply with the requirements of this section if an appropriate drug or alcohol treatment program is unavailable.~~ The Social Services Commission shall adopt rules pertaining to the testing of applicants and recipients under this section.

(e) Area mental health authorities organized pursuant to Article 4 of Chapter 122C of the General Statutes shall be responsible for administering the provisions of this section.

(f) ~~The requirements of this section may be waived or modified as necessary in the case of individual applicants or recipients to the degree necessary to comply with Medicaid eligibility provisions."~~

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

2

SENATE BILL 594
Judiciary II Committee Substitute Adopted 4/10/13

Short Title: Require Drug Testing/Work First Benefits.

(Public)

Sponsors:

Referred to:

April 4, 2013

A BILL TO BE ENTITLED
AN ACT TO REQUIRE DRUG SCREENING FOR APPLICANTS FOR AND RECIPIENTS
OF WORK FIRST PROGRAM ASSISTANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-29.1 reads as rewritten:

"§ 108A-29.1. Substance abuse treatment required; drug testing required for Work First Program applicants and recipients.

(a) ~~Each applicant or current recipient of Work First Program benefits, determined by a Qualified Professional in Substance Abuse (QPSA) or by a physician certified by the American Society of Addiction Medicine (ASAM) to be addicted to alcohol or drugs and to be in need of professional substance abuse treatment services shall be required, as part of the person's MRA and as a condition to receiving Work First Program benefits, to participate satisfactorily in an individualized plan of treatment in an appropriate treatment program. As a mandatory program component of participation in an addiction treatment program, each applicant or current recipient shall be required to submit to an approved, reliable, and professionally administered regimen of testing for presence of alcohol or drugs, without advance notice, during and after participation, in accordance with the addiction treatment program's individualized plan of treatment, follow up, and continuing care services for the applicant or current recipient. The Department shall require a drug test to screen each applicant for or recipient of Work First Program assistance. The cost of the drug testing is the responsibility of the individual tested. The Department shall provide notice of drug testing to each applicant or recipient. The notice shall advise the applicant or recipient that drug testing will be conducted as a condition of receiving Work First Program assistance, and that the results of the drug tests will remain confidential and will not be released to law enforcement. The applicant or recipient shall be advised that the required drug testing may be avoided if the applicant or recipient does not apply for Work First Program assistance. Dependent children under the age of 18 are exempt from the requirements of this section. The Department shall require the following:~~

- (1) That for two-parent families, both parents comply with the drug-testing requirement.
- (2) That any teen parent who is emancipated pursuant to Article 35 of Chapter 7B of the General Statutes comply with the drug-testing requirement.
- (3) That each applicant or recipient be advised before testing that he or she may inform the agent administering the test of any prescription or over-the-counter medication he or she is taking.



* S 5 9 4 - V - 2 *

1 (4) That each applicant or recipient being tested to sign a written
2 acknowledgement that he or she has received and understood the notice and
3 advice provided under this subsection.

4 (5) That each applicant or recipient who fails a drug test understands that he or
5 she has the right to take one or more additional tests.

6 (b) ~~An applicant or current recipient who fails to comply with any requirement imposed~~
7 ~~pursuant to this section shall not be eligible for benefits or shall be subject to the termination of~~
8 ~~benefits, but shall be considered to be receiving benefits for purposes of determining eligibility~~
9 ~~for medical assistance. For an applicant or current recipient who tests negative for controlled~~
10 ~~substances, the Department shall increase the amount of the initial Work First Program~~
11 ~~assistance by the amount paid by the applicant or recipient for the drug testing. An applicant or~~
12 ~~recipient who tests positive for controlled substances as a result of a drug test required under~~
13 ~~this section is ineligible to receive Work First Program assistance for one year from the date of~~
14 ~~the positive drug test except as provided in subsection (b1) of this section. The individual may~~
15 ~~reapply after one year. However, if the individual has any subsequent positive drug tests, the~~
16 ~~individual shall be ineligible for benefits for three years from the date of the subsequent~~
17 ~~positive drug test unless the individual reapplies pursuant to subsection (b1) of this section.~~

18 (b1) An applicant or recipient deemed ineligible may reapply for Work First Program
19 assistance if the individual can document the successful completion of a substance abuse
20 treatment program offered by a provider under subsection (e) of this section and licensed by the
21 Department. The applicant or recipient who reapplies for Work First Program assistance after
22 completion of a substance abuse program shall pass a drug test. The cost of any drug testing
23 and substance abuse program provided under this subsection shall be the responsibility of the
24 applicant or recipient being tested and receiving treatment. An applicant or recipient who
25 reapplies for Work First Program assistance pursuant to this subsection may reapply one time
26 only.

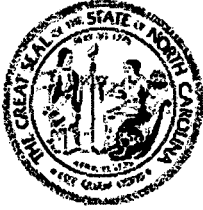
27 (c) The children of any applicant or current recipient shall remain eligible for benefits,
28 and these benefits shall be paid to a protective payee pursuant to G.S. 108A-38.

29 (d) ~~An applicant or current recipient shall not be regarded as failing to comply with the~~
30 ~~requirements of this section if an appropriate drug or alcohol treatment program is~~
31 ~~unavailable. The Social Services Commission shall adopt rules pertaining to the testing of~~
32 ~~applicants and recipients under this section.~~

33 (e) Area mental health authorities organized pursuant to Article 4 of Chapter 122C of
34 the General Statutes shall be responsible for administering the provisions of this section.

35 (f) ~~The requirements of this section may be waived or modified as necessary in the case~~
36 ~~of individual applicants or recipients to the degree necessary to comply with Medicaid~~
37 ~~eligibility provisions."~~

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



SENATE BILL 594: Require Drug Testing/Work First Benefits

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sen. J. Davis
Analysis of: Second Edition

Date: April 16, 2013
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *Senate Bill 594 would require drug testing for applicants and recipients of the Work First Program.*

CURRENT LAW: Through Work First, North Carolina's Temporary Assistance for Needy Families (TANF) program, parents can get short-term training and other services to help them become employed and self-sufficient. The Work First Program is governed by Part 2 of Article 2 of Chapter 108A of the General Statutes (G.S. 108A-27 through 108A-39). G.S. 108A-29.1 requires that each applicant or recipient of Work First Program benefits who is determined by a substance abuse professional or physician to be addicted to alcohol or drugs and to be in need of professional substance abuse treatment services must participate satisfactorily in an individualized plan of treatment. As a mandatory component of participation in an addiction treatment program, an applicant or recipient is required to submit to testing for the presence of alcohol or drugs.

BILL ANALYSIS: Senate Bill 594 would direct the Department of Health and Human Services (DHHS) to require a drug test to screen each applicant or recipient of Work First Program assistance. Each applicant and recipient must be provided notice that includes a statement that drug testing will be conducted as a condition of receiving Work First Assistance and that the results of the drug tests will remain confidential and will not be released to law enforcement. Dependent children under the age of 18 would be exempt from the drug testing requirement. For two-parent families, each parent would be required to comply with the drug testing requirement. The cost of the drug testing would be the responsibility of the individual tested. If the person tests negative, the initial payment of benefits would include reimbursement of the cost of the drug testing.

A person who tests positive would be ineligible to receive Work First Program assistance for a period of one year from the date of the positive drug test, and may reapply after one year; a person who has a subsequent positive drug test would be ineligible for a period of three years from the date of the subsequent drug test. However, a person would be eligible to reapply with documentation of successful completion of a substance abuse treatment program offered by an area mental health authority and licensed by DHHS. The applicant who reapplies after completion of a treatment program would be required to pass a drug test, and would be responsible for the cost of the test. A person may only reapply one time based on completion of a substance abuse treatment program. The Social Services Commission would be required to adopt rules pertaining to the testing of applicants and recipients.

The children of any applicant or current recipient would remain eligible for benefits, and those benefits would be paid to a protective payee. The bill would eliminate a provision allowing a person who is ineligible for benefits or subject to the termination of benefits due to substance abuse to be considered as receiving benefits for purposes of determining eligibility for medical assistance. It would also eliminate a provision that states an applicant or current recipient will not be regarded as failing to comply if an appropriate drug or alcohol treatment program is unavailable, and that provides for waiver or modification of the requirements to comply with Medicaid eligibility provisions.

EFFECTIVE DATE: The bill would be effective when it becomes law.

Brenda Carter, counsel to Senate Judiciary II, substantially contributed to this summary.

O. Walker Reagan
Director



Research Division
(919) 733-2578

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. 2

H. B. No. _____

DATE 4-17-13

S. B. No. 594

Amendment No. _____

COMMITTEE SUBSTITUTE _____

(to be filled in by
Principal Clerk)

Rep.)

Sen.)

Paumon

1 moves to amend the bill on page 1, line 28

2 () WHICH CHANGES THE TITLE

3 by rewriting the line to read:

4 _____

5 (1) That for two-parent households, both

6 parents comply with the drug-testing".

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

14 _____

15 _____

16 _____

17 _____

18 _____

19 _____

SIGNED

Earline H. Warner

ADOPTED _____ FAILED _____ TABLED _____



COMMENTS SUBMITTED TO THE HEALTH CARE COMMITTEE
April 18, 2013

SB 606 **Chronic Care Coordination Act**

Senators Hise and Barringer,

Boehringer Ingelheim is pleased to submit these comments in support of SB 606, the Chronic Care Coordination Act, and its companion HB 459. As you know, HB 459 already passed the House Health Policy Committee intact on April 9, 2013.

Boehringer Ingelheim is a family owned company committed to the discovery, development, manufacture and marketing of innovative health care products that have helped bring more health to patients and address unmet therapeutic needs. We recognize that chronic conditions are a significant issue facing states, and we are committed to continuing to make advances in chronic disease areas that are of critical importance to patients and their families.

There is considerable evidence about how to prevent, postpone and treat these chronic conditions. Implementing evidence-based prevention strategies can reduce health care costs borne by states for its employees, state retirees and its low-income and disabled populations enrolled in Medicaid. One estimate is that 83 cents of every Medicaid dollar is spent on preventable and highly manageable chronic diseases, including diabetes, asthma and hypertension.¹

According to the Center for Disease Control, seven in ten deaths in the United States are caused by chronic diseases, a total of 1.7 million deaths each year.² These conditions include heart disease, cancer, stroke, respiratory diseases and diabetes, and mental health disorders which are estimated to contribute more than \$1 trillion in spending across the U.S. each year.³

Attached is a 2012 resolution from the Council of State Governments (CSG) which recommends that states become more aware of strategies that address Chronic Care Coordination.

SB 606 establishes a working group to develop a plan to reduce incidences of chronic disease and improve chronic care coordination. The bill further requires this group to report to this committee and the Governor about the impact of the chronic diseases that are most likely to cause death or disability, the approximate number of people in the state affected by these chronic diseases and an inventory of programs in the state that have been implemented to improve chronic care coordination. The goal of this bill is to reduce the incidence of chronic disease in this state and to coordinate care for patients with multiple chronic conditions.

¹ Partnership To Fight Chronic Disease. (2011) "Medicaid in a New Era: Proven Solutions to Enhance Quality and Reduce Costs." <http://www.fightchronicdisease.org/events/medicaid-new-era-proven-solutions-enhance-quality-and-reduce-costs>

² Centers for Disease Control and Prevention. <http://www.cdc.gov/chronicdisease/index.htm>, accessed March 6, 2013.

³ DeVol, Ross, et al. "An Unhealthy America: The economic burden of chronic disease." The Milken Institute. October 2007.

While we recognize and applaud the work that the State Department of Public Health has done over the years by identifying and establishing plans for many of the chronic diseases, we believe there is still a need to look at the diseases together and come up with recommendations on how best to treat them all in a coordinated fashion with the limited resources that are available.

--- passage of this bill will help provide a comprehensive and consolidated strategy to identifying best practices for addressing chronic care coordination in an effort to take steps to reduce the burden of multiple chronic conditions on the state and its residents.

Thank you for your time and consideration of our comments. If you have any questions please contact Matt Sheffield, BI National Government Affairs Executive Director, Raleigh, NC @919-556-6491.

While we recognize and applaud the work that the State Department of Public Health has done over the years by identifying and establishing plans for many of the chronic diseases, we believe there is still a need to look at the diseases together and come up with recommendations on how best to treat them all in a coordinated fashion with the limited resources that are available.

... passage of this bill will help provide a comprehensive and consolidated strategy to identifying best practices for addressing chronic care coordination in an effort to take steps to reduce the burden of multiple chronic conditions on the state and its residents.

Thank you for your time and consideration of our comments. If you have any questions please contact Matt Sheffield, HI National Government Affairs Executive Director, Raleigh, NC @919-256-2491.

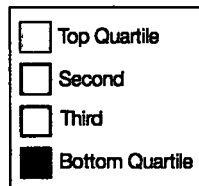
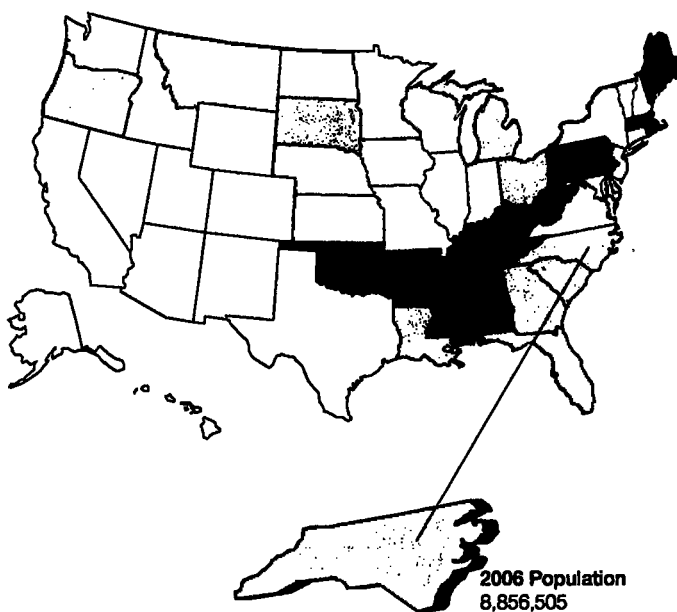
Current Toll on North Carolina TODAY

Over 5 million cases of seven common chronic diseases — cancers, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions — were reported in North Carolina in 2003. These conditions shorten lives, reduce quality of life, and create considerable burden for caregivers. The following map shows how states compare based on the prevalence of the seven common chronic diseases.

Reported Cases in North Carolina, 2003 (and as % of population*)

Cancers:	297,000	(3.6%)
Diabetes:	427,000	(5.2%)
Heart Disease:	537,000	(6.6%)
Hypertension:	1,192,000	(14.6%)
Stroke:	80,000	(1.0%)
Mental Disorders:	993,000	(12.2%)
Pulmonary Conditions:	1,513,000	(18.6%)

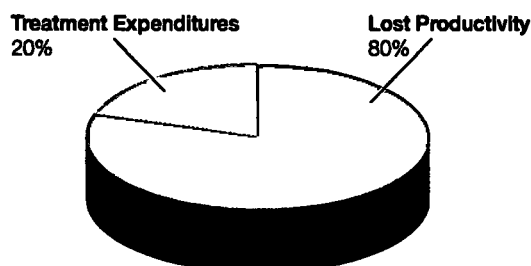
* As % of non-institutionalized population. Number of treated cases based on patient self-reported data from 2003 MEPS. Excludes untreated and undiagnosed cases.



Milken Institute State Chronic Disease Index

States in the top quartile have the lowest rates of seven common chronic diseases.

And while the human cost is enormous, the economic cost also is great. The cost of treating these conditions — without even taking into consideration the many secondary health problems they cause — totaled \$7.9 billion in 2003. These conditions also reduce productivity at the workplace, as ill employees and their caregivers are often forced either to miss work days (absenteeism) or to show up but not perform well (presenteeism). The impact of lost workdays and lower employee productivity resulted in an annual economic loss in North Carolina of \$32.1 billion in 2003.



Economic Impact in North Carolina 2003 (Annual Costs in Billions)

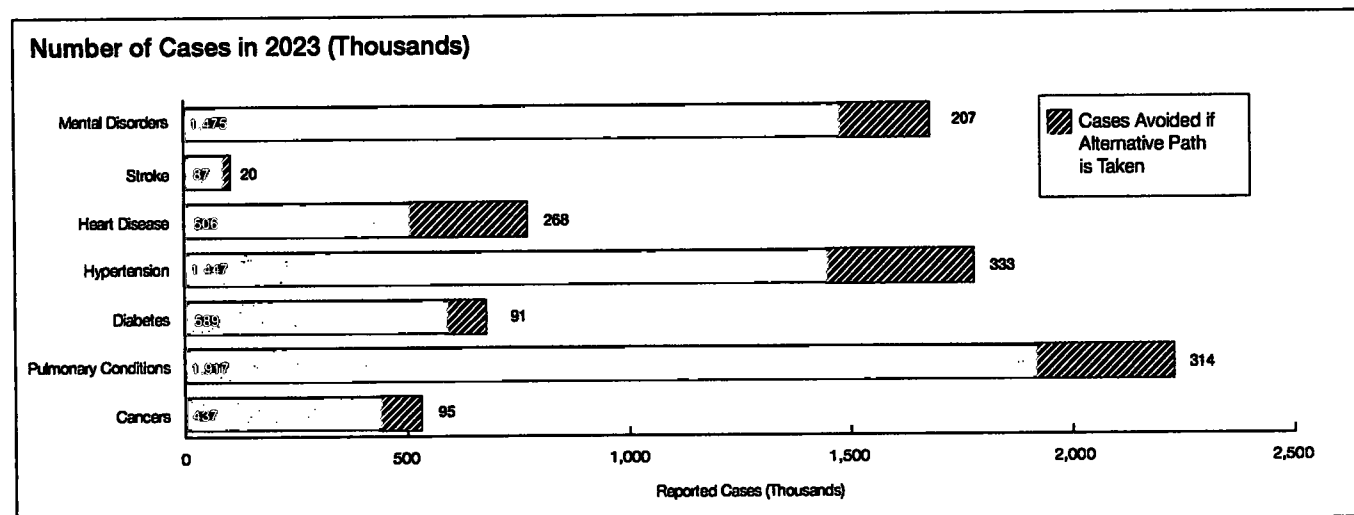
Treatment Expenditures:	\$7.9
Lost Productivity:	\$32.1
Total Costs:	\$40.0

Figures may not sum due to rounding.

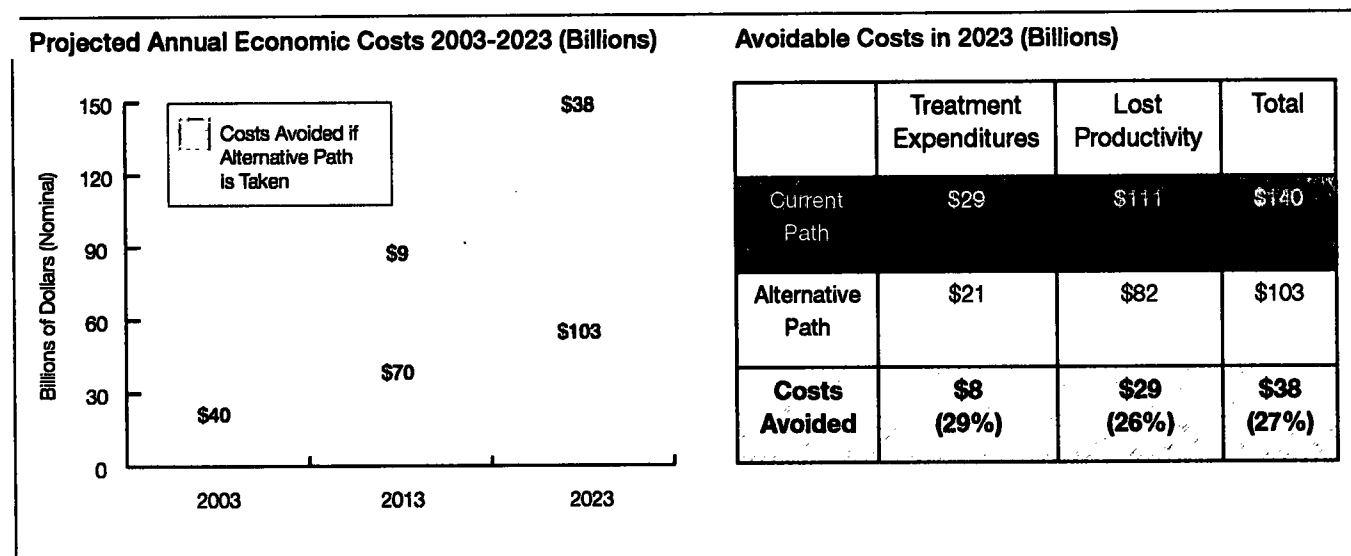
MILKEN INSTITUTE

Two Paths, Two Choices — Chronic Disease in North Carolina TOMORROW

On our current path, North Carolina will experience a dramatic increase in chronic disease in the next 20 years. But there is an **alternative path**. By making reasonable improvements in preventing and managing chronic disease, we can avoid 1.4 million cases of chronic conditions in 2023.



Reasonable improvements in preventing and managing chronic disease could reduce future economic costs of disease in North Carolina sharply, by 27% (\$38 billion) in 2023. \$29 billion of this would come from gains in productivity, and \$8 billion would come from reduced treatment spending.



And the impact on economic output *compounds* over time.

These improvements in health will increase investments in human and physical capital, driving additional economic growth a generation from now. By 2050, reasonable disease prevention and management efforts could add \$170 billion to the state's economic output, a boost of 18%.

Real GDP in 2050

(In billions 2003 dollars)

GDP in 2050, Current Path:	\$967
GDP in 2050, Alternative Path:	\$1,137
Potential Gain in GDP:	\$170 (18%)

Figures may not sum due to rounding.



Chronic Care Initiative Frequently Asked Questions (FAQ'S)

What does the Chronic Care Initiative seek to do?

The legislation seeks coordination of efforts by state on data and efforts to focus on patients with multiple chronic conditions. State agencies should use existing funds and potentially grant support from the Centers for Disease Control (CDC), as well as available state data on prevalence and cost of chronic disease. Leveraging current funds and data will enable the state to improve quality of care for its residents without raising costs.

The proposal calls for a report to a) assess prevalence and burden of chronic conditions in the state, b) highlight existing programs to improve health care, and c) develop a state plan to decrease costs and improve health outcomes. The report could show how comprehensive medication management improves medication use while covering gaps in care for patients with multiple chronic conditions.

How will this promote health care savings in North Carolina?

According to the Center for Disease Control, seven in ten deaths in the United States are caused by chronic diseases, a total of 1.7 million deaths each year. Chronic conditions include heart disease, cancer, stroke, respiratory diseases and diabetes, and mental health disorders which are estimated to contribute more than \$1 trillion in spending across the U.S. each year.¹

In North Carolina, over 5 million cases of seven common chronic diseases — cancers, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions — were reported. The cost of treating these conditions resulted in \$7.9 billion in 2003, plus the impact of lost workdays and lower employee productivity resulted in an annual economic loss of \$32.1 billion².

Why a Chronic Care Initiative now?

According to the World Health Organization (WHO), the leading chronic diseases include heart disease, stroke, diabetes, chronic respiratory illness and cancer³. The inefficient coordination of care for people with multiple chronic conditions has led not only to higher costs, but poorer health outcomes for these vulnerable populations.

Implementing evidenced-based prevention strategies can reduce health care costs borne by states for its employees, state retirees and its low-income and disabled populations enrolled in Medicaid. One estimate is that 83 cents of every Medicaid dollar is spent on preventable and highly manageable chronic diseases, including diabetes, asthma and hypertension.⁴

Is this a mandate on health plans?

This legislation hopes to inspire rather than require private health plans to coordinate care for patients with multiple chronic conditions and implement medication management.

¹ DeVol, Ross, et al. "An Unhealthy America: The economic burden of chronic disease." The Milken Institute. October 2007.

² Ibid.

³ http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf, accessed Oct. 2, 2012.

⁴ Centers for Disease Control and Prevention. <http://www.cdc.gov/chronicdisease/index.htm>, accessed March 6, 2013.



VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/17/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Sarah Wolfe	MNCCLC
Tara Chandra Sekhar	UNC Hospitals
Tiona Praylow	UNC HOSPITALS
Tranite	Am
DANIEL VAN LIERE	VIOANT HEALTH
Susanna Davis	Williams Mullen
Allison Waller	Nelson Mullen
JAY PETERS	CSS
Jay Peters	CSS
RC Penzance	CSS
Siham Hontasser	Wake Forest
Shahzad Ali	Wake Forest Univ
Amy White	NC med Society
Aminda Honaker	Troutman Sanders
Linda Kearsley	Senior Services, Inc.
Christina M. Acosta	WellSpring Retirement
Betsy Votter	Amer Heart Assn

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/17/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Mary B. H. H.	AARP - NC
R.D. Faggart	Cabarrus Professional Firefighters Concord 28025
Jeffrey Hopkins	Professional Fire Fighters Paramedics of NC
Joe Donovan	SC NC
ALAN BRIGGS	NC Food Banks
Larry PAKSOY	NH/SW - NC
Todd Bahr	NC Advocates for Justice
John Hards	MFTS
Michelle Frazier	MFTS
Chris Bygott	NCHS
Rab Hamme	RAA
Fred Bone	Bone Assoc.
AWE Lachiewicz	Duke Pediatrics

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/17/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
T Leeburgin	ADTS of Rockingham Co.
Julia Adams	The Arc of NC/ NCARF
Sarah Preston	ACLU - NC
Mark Botts	UNC - SOG
Sally Cameron	NC Psychological Assoc
DIANNA Talley	Warren Co. DSU
Cathy Barton	ACCFA - Alamance County
Ruth Powers	ADTS of Rockingham Cty.
Vicki Bayer	Self
Tim McHugh	JS
Andrew Blackburn	SSG NK
Jacob Yarnall	Sgt. Brown's Office
CARLY Baker	UNC-JOMC
Debra Bolick, MD	North Carolina Psych. Assoc.
Ken Melton	K. M. A.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/17/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Don Bidez, MD	UNC Chapel Hill
Amy Fowler MD	UNC Chapel Hill
AMIT KUMAR, MD	CAROLINA RETINA INST. CARY, NC
Bradley King, MD MPH	UNC ophthalmology.
MICHAEL COMPTON, MD	UNC CHAPEL HILL ophthalmology
Will Barnett	NCMS
Lori Ann Harris	LATTA
Paula Joppe	NCANCP
W. Rafter Jr	NCDS & NCPHA
Benton Albritton	ABC Carolinas
George Smith	NP
Mike Okun	NC fkt AG-100
Patricia Murran	Winston-Salem Police
Jason Fishkin	Senate
Tanice Tyler	Orange County Dept on Aging
Marti Zboria	Lenoir County Senior Services
Richard Smith	Senior Resources of Guilford

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 4-17 TIME: 11 AM

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

Page Name	Hometown	Sponsoring Senator
1 Maranda Judd	Holly Springs	Berger
2 Treston Farrington	Holly Springs	Berger
3 Candace Brown	Raleigh	Berger
4 Karen Metts	Trenton	Brown
5		
6		
7		
8		
9		
10		

Do not add names below the grid.

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

**Senate Committee on Health Care
Wednesday, April 24, 2013, 11:00 AM
544 Legislative Office Building**

Senator Ralph Hise, Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages and Sergeants-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 473	HealthCare Cost Reduction & Transparency.	Senator Rucho Senator Brown
SB 137	Prohibit Co-pay Waiver/Medicaid Providers.	Senator Tillman

Adjournment

**Senate Committee on Health Care
Wednesday, April 24, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on April 24, 2013 in Room 544 of the Legislative Office Building. Eighteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise called the meeting to order by recognizing the Pages—Natalie Brown of Wayne County, Briggs Manness of Polk County, and Caleb Sanders of Burke County; and the Sergeants-at-Arms—Donna Blake, Billy Fritscher, Ed Kesler, Ashley Mickens, and Steve Wilson.

Senator Tillman was recognized to present Senate Bill 137 – Prohibit Co-pay Waiver/Medicaid Providers. Senator Pate moved for adoption of the PCS for Senate Bill 137. Senator Tillman explained the purpose of the bill; Senator Wade moved for a favorable report to the PCS, unfavorable to the original bill. The PCS passed.

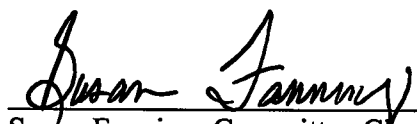
Senator Brown was recognized to present Senate Bill 473 – Health Care Cost Reduction & Transparency. Senator Hise moved for adoption of the PCS for Senate Bill 473. Senators Brown and Rucho spoke briefly on the bill. Barbara Reilly, staff, explained the bill in detail. Senator Hise opened the floor for technical questions from members. Two members of the public spoke for two minutes each—Hugh Tilson, Sr. VP of the NC Hospital Association, and Mark Fleming of Blue Cross Blue Shield of NC.

Senator Hartsell was recognized to present an amendment. The amendment failed. Senator McKissick moved for a favorable report to the PCS, unfavorable to the original bill. The PCS passed and was referred to the Finance Committee.

The meeting adjourned at 11:55 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

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 24, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 473	HealthCare Cost Reduction & Transparency.	Senator Rucho Senator Brown
SB 137	Prohibit Co-pay Waiver/Medicaid Providers.	Senator Tillman

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Thursday, April 25, 2013

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

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

SB 473

HealthCare Cost Reduction & Transparency.

Draft Number: S473-PCS75292-RF-9

Sequential Referral: Finance

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Robert Rucho will handle SB 473



★ C M R 3 8 6 - V - 1 ★

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

CORRECTED REPORT

Wednesday, April 24, 2013

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

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

SB 137

Prohibit Co-pay Waiver/Medicaid Providers.

Draft Number: S137-PCS75287-TK-4

Sequential Referral: None

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Jerry Tillman will handle SB 137



* C M R 3 7 5 - V - 4 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 137

Short Title: Prohibit Co-pay Waiver/Medicaid Providers.

(Public)

Sponsors: Senators Tillman (Primary Sponsor); Bingham, Brock, Hise, and Pate.

Referred to: Health Care.

February 27, 2013

A BILL TO BE ENTITLED
AN ACT TO PROVIDE THAT THE REGULAR BUSINESS PRACTICE OF WAIVING
REQUIRED MEDICAID RECIPIENT CO-PAYMENTS BY A MEDICAID PROVIDER
CONSTITUTES FRAUD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-63 reads as rewritten:

"§ 108A-63. Medical assistance provider fraud.

(a) It shall be unlawful for any provider of medical assistance under this Part to knowingly and willfully make or cause to be made any false statement or representation of a material fact:

- (1) In any application for payment under this Part, or for use in determining entitlement to such payment; or
- (2) With respect to the conditions or operation of a provider or facility in order that such provider or facility may qualify or remain qualified to provide assistance under this Part.

(b) It shall be unlawful for any provider of medical assistance to knowingly and willfully conceal or fail to disclose any fact or event affecting:

- (1) His initial or continued entitlement to payment under this Part; or
- (2) The amount of payment to which such person is or may be entitled.

(c) Except as otherwise provided in subsection (e) of this section, any person who violates a provision of this section shall be guilty of a Class I felony.

(d) "Provider" shall include any person who provides goods or services under this Part and any other person acting as an employee, representative or agent of such person.

(e) In connection with the delivery of or payment for benefits, items, or services under this Part, it shall be unlawful for any provider of medical assistance under this Part to knowingly and willfully execute, or attempt to execute, a scheme or artifice to:

- (1) Defraud the Medical Assistance Program.
- (2) Obtain, by means of false or fraudulent pretenses, representations, or promises of material fact, any of the money or property owned by, or under the custody or control of, the Medical Assistance Program.
- (3) Waive the collection of co-payments owed by recipients of medical assistance as required under the Medical Assistance Program with the intent to induce recipients to purchase, lease, or order items or services from the provider.

A violation of this subsection is a Class H felony. A conspiracy to violate this subsection is a Class I felony.



* S 1 3 7 - V - 1 *

(f) It shall be unlawful for any provider, with the intent to obstruct, delay, or mislead an investigation of a violation of this section by the Attorney General's office, to knowingly and willfully make or cause to be made a false entry in, alter, destroy, or conceal, or make a false statement about a financial, medical, or other record related to the provision of a benefit, item, or service under this Part.

(g) It shall be unlawful for any person to knowingly and willfully solicit or receive any remuneration (including any kickback, bribe, ~~or rebate~~ rebate, or waiver of a co-payment owed by a recipient of medical assistance) directly or indirectly, overtly or covertly, in cash or in-kind:

(1) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this Part.

(2) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this Part.

(h) It shall be unlawful for any person to knowingly and willfully offer or pay any remuneration (including any kickback, bribe, ~~or rebate~~ rebate, or waiver of a co-payment owed by a recipient of medical assistance) directly or indirectly, overtly or covertly, in cash or in-kind to any person to induce such person:

(1) To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this Part.

(2) To purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this Part.

(i) Subsections (g) and (h) of this section shall not apply to:

(1) Contracts between the State and a public or private agency where part of the agency's responsibility is referral of a person to a provider.

(2) Any conduct or activity that is specified in 42 U.S.C. § 1320a-7b(b)(3), as amended, or any federal regulations adopted pursuant thereto.

(i1) For enforcement purposes, a provider that waives a co-payment owed by a recipient of medical assistance in violation of subsections (g) and (h) of this section shall be considered in violation of those subsections regardless of the monetary amount that is waived by the provider. A provider of medical assistance shall not be in violation of subsections (g) and (h) of this section if the provider waives a co-payment owed by a recipient of medical assistance for any of the following reasons:

(1) The waiver is authorized under the Medical Assistance Program.

(2) The provider determines on an individual basis that the collection of the co-payment amount would create a substantial financial hardship for the recipient, provided the waiver of co-payments is not a regular business practice of the provider. For the purposes of this subdivision, a provider shall be considered engaged in the regular business practice of waiving co-payments if the provider holds himself or herself out to recipients as waiving required co-payments.

(3) The provider has made a good faith effort to collect the co-payment amount but the provider's reasonable collection efforts fail.

(i2) For the purposes of this section, the waiver of a co-payment includes a full or partial waiver of the amount that is owed by the recipient of medical assistance.

(j) Nothing in subsections (g) and (h) of this section shall be interpreted or construed to conflict with 42 U.S.C. § 1320a-7b(b), as amended, ~~or with federal common law or federal agency interpretations of the statute amended.~~

1 (k) The Department shall suspend or terminate a provider's participation in the Medical
2 Assistance Program if the provider is convicted of a violation of this section, whether upon a
3 verdict after trial or upon a plea of guilty or nolo contendere, in accordance with administrative
4 sanctions and remedial measures established by the Department. The administrative sanctions
5 or remedial measures required by this subsection shall be in addition to the imposition of any
6 criminal penalties."

7 **SECTION 2.** G.S. 108A-70.12(a) reads as rewritten:

8 "(a) Liability for Certain Acts. – It shall be unlawful for any provider of medical
9 assistance under the Medical Assistance Program ~~to do any of the following:~~

10 (1) Knowingly present, or cause to be presented to the Medical Assistance
11 Program a false or fraudulent claim for payment or ~~approval; or approval.~~

12 (2) Knowingly make, use, or cause to be made or used a false record or
13 statement to get a false or fraudulent claim paid or approved by the Medical
14 Assistance Program.

15 (3) Knowingly waive a co-payment, in part or in full, owed by a recipient of
16 medical assistance related to a claim presented to the Medical Assistance
17 Program for payment or approval. A provider may be found in violation of
18 this subdivision regardless of the monetary amount that is waived by the
19 provider. A provider of medical assistance is not in violation of this
20 subdivision if the provider waives a co-payment, in part or in full, owed by a
21 recipient of medical assistance for any of the following reasons:

22 a. The waiver is authorized under the Medical Assistance Program.

23 b. The provider determines on an individual basis that the collection of
24 the co-payment amount would create a substantial financial hardship
25 for the recipient, provided the waiver of co-payments is not a regular
26 business practice of the provider. For the purposes of this
27 sub-subdivision, a provider shall be considered engaged in the
28 regular business practice of waiving co-payments if the provider
29 holds himself or herself out to recipients as waiving required
30 co-payments.

31 c. The provider has made a good faith effort to collect the co-payment
32 amount but the provider's reasonable collection efforts fail.

33 Each claim presented or caused to be presented in violation of this section is a separate
34 violation."

35 **SECTION 3.** This act becomes effective December 1, 2013, and applies to acts and
36 offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 137
PROPOSED COMMITTEE SUBSTITUTE S137-PCS75287-TK-4

Short Title: Prohibit Co-pay Waiver/Medicaid Providers.

(Public)

Sponsors:

Referred to:

February 27, 2013

A BILL TO BE ENTITLED
AN ACT TO PROHIBIT THE REGULAR BUSINESS PRACTICE OF WAIVING
REQUIRED MEDICAID AND HEALTH CHOICE RECIPIENT CO-PAYMENTS BY
CERTAIN PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 108C of the General Statutes is amended by adding a new
section to read:

"§ 108C-13. Certain waivers of Medicaid and Health Choice co-payments prohibited.

(a) No provider that has obtained a permit pursuant to G.S. 90-85.21 or G.S. 90-85-21A
shall waive the collection of co-payments owed by recipients of Medicaid and Health Choice,
as required by the respective program, with the intent to induce recipients to purchase, lease, or
order items or services from the provider. For enforcement purposes, a provider that waives a
co-payment owed by a recipient of Medicaid or Health Choice is in violation of this subsection
regardless of the monetary amount that is waived by the provider. A provider shall not be in
violation of this subsection if the provider waives a co-payment owed by a recipient of
Medicaid or Health Choice for any of the following reasons:

- (1) The waiver is authorized under the Medical Assistance Program or the North
Carolina Health Insurance Program for Children.
- (2) The provider determines on an individual basis that the collection of the
co-payment amount would create a substantial financial hardship for the
recipient, provided the waiver of co-payments is not a regular business
practice of the provider. For the purposes of this subdivision, a provider shall
be considered engaged in the regular business practice of waiving
co-payments if the provider holds himself or herself out to recipients as
waiving required co-payments.
- (3) The provider has made a good faith effort to collect the co-payment amount,
but the provider's reasonable collection efforts fail.
- (4) The provider is a health care facility regulated pursuant to Chapter 131E or
Chapter 122C of the General Statutes or that is owned or operated by the
State of North Carolina.

(b) A violation of this section shall result in suspension or termination by the
Department of a provider's participation in Medicaid and Health Choice in accordance with
administrative sanctions and remedial measures established by the Department for violations of
this section."

SECTION 2. This act becomes effective October 1, 2013, and applies to acts
committed on or after that date.



* S 1 3 7 - P C S 7 5 2 8 7 - T K - 4 *



SENATE BILL 137: Prohibit Co-pay Waiver/Medicaid Providers

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sen. Tillman
Analysis of: PCS to First Edition
S137-CSTK-4

Date: April 19, 2013
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate Bill 137 prohibits waiver of a co-payment owed by a Medicaid or Health Choice recipient by certain providers with the intent to induce Medicaid or Health Choice recipients to purchase, lease, or order items or services from a provider. The penalty for violation under Senate Bill 137 would be suspension or termination of the provider from the Medicaid program.*

BILL ANALYSIS:

Section 1 of the PCS to Senate Bill 137 creates a new section of Chapter 108C of the General Statute, G.S. 108C-13. The bill prohibits the following act if a provider has obtained a permit pursuant to G.S. 90-85.21 or G.S. 90-85.21 (the statutes regulating pharmacies):

Waiver of the collection of copayments owed by a recipients of medical assistance, as required by the Medicaid or Health Choice, with the intent to induce recipients to purchase, lease, or order items or services from the provider.

The act of waiving a co-payment by these certain providers is prohibited regardless of the amount waived. A provider is not in violation if any of the following applies:

- The waiver is authorized under the Medical Assistance Program or NC Health Insurance Program for Children (Health Choice).
- The provider determines that collection of the co-payment would create a substantial financial hardship for the recipient, provided that the waiver of co-payments is not a regular business practice of the provider.
- The provider has made a good faith effort to collect the co-payment, but the efforts have failed.
- The provider is a healthcare facility regulated pursuant to Chapter 131E (hospitals and health care facilities, such as long-term care facilities) or Chapter 122C (facilities of for the mentally ill, developmentally disabled and substance abuse) of the General Statutes.

Under the PCS, if a provider is found to be in violation, Senate Bill 137 directs the Department of Health and Human Services (Department) to suspend or terminate the provider's participation in the Medicaid and Health Choice programs in accordance with administrative sanctions and remedial measures established by the Department.

O. Walker Reagan
Director



Research Division
(919) 733-2578

Senate PCS 137

Page 2

Senate Bill 137 also specifies that a provider is considered to be engaged in the regular business practice of waiving co-payments if the provider holds himself or herself out to recipients as waiving required co-payments.

The PCS makes changes to location of the statute, removing it from the statutes involving Medicaid fraud and false claims.

EFFECTIVE DATE: This act becomes effective October 1, 2013, and applies to acts committed on or after that date.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

1

SENATE BILL 473

Short Title: HealthCare Cost Reduction & Transparency. (Public)

Sponsors: Senators Rucho, Brown (Primary Sponsors); Barefoot, Brock, Hise, Hunt,
Jackson, Meredith, Pate, Rabin, and Tillman.

Referred to: Health Care.

March 28, 2013

A BILL TO BE ENTITLED
AN ACT TO IMPROVE TRANSPARENCY IN THE COST OF HEALTH CARE
PROVIDED BY HOSPITALS AND AMBULATORY SURGICAL FACILITIES; TO
TERMINATE SET-OFF DEBT COLLECTION BY CERTAIN STATE AGENCIES
PROVIDING HEALTH CARE TO THE PUBLIC; TO PROHIBIT HOSPITALS AND
AMBULATORY SURGICAL FACILITIES FROM CHARGING MULTIPLE TIMES
FOR OUTPATIENT RADIOLOGY SERVICES RENDERED ONLY ONCE; TO
MODIFY THE HOSPITAL PROVIDER ASSESSMENT ACT; AND TO ENCOURAGE
COMMUNITY CARE OF NORTH CAROLINA TO ADJUST ITS CORPORATE
GOVERNANCE.

The General Assembly of North Carolina enacts:

PART I. TITLE

SECTION 1. This act shall be known as the Health Care Cost Reduction and
Transparency Act of 2013.

PART II. TRANSPARENCY IN HEALTH CARE COSTS

SECTION 2. G.S. 90-413.2 reads as rewritten:

"§ 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. This Article is also intended to improve transparency in
health care costs by providing information to the public on the cost of the 50 most common
episodes of care in hospitals subject to the North Carolina Hospital Licensure Act and
ambulatory surgical facilities subject to the North Carolina Ambulatory Surgical Facility
Licensure Act.

SECTION 3. Article 29A of Chapter 90 of the General Statutes is amended by
adding a new section to read:

"§ 90-413.9. Disclosure of prices for most common episodes of care.

The NC HIE shall provide free public access to the most current information it receives
from hospitals and ambulatory surgical facilities pursuant to G.S. 131E-91.1 and



* S 4 7 3 - V - 1 *

1 G.S. 131E-153 on an Internet Web site established and maintained by the NC HIE that is
2 available to the general public. The NC HIE shall provide this information in a manner that is
3 easily understood by the public and meets the following minimum requirements:

- 4 (1) Information for each hospital shall be listed separately, and hospitals shall be
5 listed in groups by category, as determined by the North Carolina Medical
6 Care Commission in rules adopted pursuant to G.S. 131E-91.1.
- 7 (2) Information for each ambulatory surgical facility shall be listed separately.
- 8 (3) Information concerning the most common episodes of care for each hospital
9 shall include a separate listing of the facility fees charged by health care
10 providers affiliated with the hospital.
- 11 (4) Information concerning the most common episodes of care for each
12 ambulatory surgical facility shall include a separate listing of the facility fees
13 charged by health care providers affiliated with the facility."

14 **SECTION 4.** Article 5 of Chapter 131E of the General Statutes is amended by
15 adding a new Part to read:

16 "Part 4A. Transparency in Health Care Costs.

17 **"§ 131E-91.1. Disclosure of prices for most common episodes of care.**

18 (a) The following definitions apply in this section:

- 19 (1) Episode of care. – All acute care hospital services related to a health
20 condition with a given diagnosis, from the three-day period preceding a
21 patient's first admission to a hospital, including readmissions, through the
22 30-day period following the patient's discharge from the hospital, for
23 treatment of the health condition. The term includes acute care hospital
24 services, services by health care providers affiliated with the hospital,
25 facility use by health care providers affiliated with the hospital, ancillary
26 services, room and board, and pharmaceuticals.
- 27 (2) Health insurer. – As defined in G.S. 108A-55.4.
- 28 (3) Public or private third party. – Includes the State, the federal government,
29 employers, health insurers, third-party administrators, and managed care
30 organizations.

31 (b) Annually on January 1, beginning January 1, 2014, each hospital licensed pursuant
32 to this Article shall provide to the North Carolina Health Information Exchange, utilizing
33 electronic health records software, the following information about the hospital's 50 most
34 common episodes of care:

- 35 (1) The amount that will be charged to a patient for each episode of care if all
36 charges are paid in full without a public or private third party paying for any
37 portion of the charges, along with a separate listing of the facility fees
38 charged by health care providers affiliated with the hospital for each episode
39 of care.
- 40 (2) The total amount of Medicaid reimbursements for each episode of care.
- 41 (3) The total amount of Medicare reimbursements for each episode of care.
- 42 (4) For each of the five largest health insurers providing payment to the hospital
43 on behalf of insureds, the range of the total amount of payments made by
44 each health insurer for each episode of care. Prior to providing this
45 information to the NC HIE, each hospital shall redact the names of the health
46 insurers and any other information that would otherwise identify the health
47 insurers.
- 48 (5) The total amount of payments made by the State Health Plan for Teachers
49 and State Employees for each episode of care.

(c) Upon request of a patient, a hospital shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.

(d) The disclosure requirements of this section shall not be construed to require a hospital licensed pursuant to this Article to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.

(e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that hospitals report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include all of the following:

(1) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the NC HIE Internet Web site.

(2) To the extent practicable, methods to ensure that hospitals report information about the most common episodes of care from a cross section of medical and surgical specialty areas identified by the Commission.

"§ 131E-91.2. Disclosure of charity care information.

(a) As used in this section, "charity care" means the costs to the hospital of providing health care or other services to a patient who is uninsured or otherwise unable to pay for all services rendered.

(b) Annually on January 1, beginning January 1, 2014, each operator of a hospital shall conspicuously post the hospital policy on charity care and the amount spent by the hospital on charity care during the preceding calendar year in the following locations:

(1) On the licensed premises in an area accessible to the public.

(2) On an Internet Web site established and maintained by the hospital and made available to the general public."

SECTION 5. G.S. 131E-91, currently codified in Part 4 of Article 5 of Chapter 131E of the General Statutes, is recodified in Part 4A of Article 5 of Chapter 131E of the General Statutes and reads as rewritten:

"§ 131E-91. Itemized charges on discharged patient's bill.

(a) All hospitals and ambulatory surgical facilities licensed pursuant to this Chapter Article shall, upon request of the patient within 30 days of after discharge, present an itemized list of charges to all discharged patients.

(b) The Commission shall adopt rules to ensure that this section is properly implemented and that patient bills which are not itemized include notification to the patient of his the right to request an itemized bill. The Department shall not issue nor or renew a license under this Chapter Article unless the applicant has demonstrated that the requirements of this section are being met."

SECTION 6. Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding new sections to read:

"§ 131E-153. Itemized charges on discharged patient's bill.

(a) All ambulatory surgical facilities licensed pursuant to this Part shall, upon request of the patient within 30 days after discharge, present an itemized list of charges to all discharged patients.

(b) The Commission shall adopt rules to ensure that this section is properly implemented and that patient bills which are not itemized include notification to the patient of the right to request an itemized bill. The Department shall not issue or renew a license under this Part unless the applicant has demonstrated that the requirements of this section are being met.

"§ 131E-153.1. Disclosure of prices for most common episodes of care.

(a) The following definitions apply in this section:

- (1) Episode of care. – All ambulatory surgical services related to a health condition with a given diagnosis, from the three-day period preceding a patient's first admission to an ambulatory surgical facility, including readmissions, through the seven-day period following the patient's discharge from the facility, for treatment of the health condition. The term includes ambulatory surgical services, services by health care providers affiliated with the facility, facility use by health care providers affiliated with the facility, use of facility operating and recovery rooms, and pharmaceuticals.
- (2) Health insurer. – As defined in G.S. 108A-55.4.
- (3) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.
- (b) Annually on January 1, beginning January 1, 2014, each ambulatory surgical facility licensed pursuant to this Part shall provide to the North Carolina Health Information Exchange, utilizing electronic health records software, the following information about the facility's 50 most common episodes of care:
- (1) The amount that will be charged to a patient for each episode of care if all charges are paid in full without a public or private third party paying for any portion of the charges, along with a separate listing of the facility fees charged by health care providers affiliated with the hospital for each episode of care.
- (2) The total amount of Medicaid reimbursements for each episode of care.
- (3) The total amount of Medicare reimbursements for each episode of care.
- (4) For each of the five largest health insurers providing payment to the facility on behalf of insureds, the range of the total amount of payments made by each health insurer for each episode of care. Prior to providing this information to the NC HIE, each facility shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.
- (5) The total amount of payments made by the State Health Plan for Teachers and State Employees for each episode of care.
- (c) Upon request of a patient, an ambulatory surgical facility shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.
- (d) The disclosure requirements of this section shall not be construed to require an ambulatory surgical facility licensed pursuant to this Part to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.
- (e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that ambulatory surgical facilities report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include, to the extent practicable, methods to ensure that ambulatory surgical facilities report information about the most common episodes of care from a cross section of medical and surgical specialty areas identified by the Commission.
- § 131E-153.2. Disclosure of charity care information.**
- (a) As used in this section, "charity care" means the costs to the ambulatory surgical facility of providing health care or other services to a patient who is uninsured or otherwise unable to pay for all services rendered.
- (b) Annually on January 1, beginning January 1, 2014, each operator of an ambulatory surgical facility shall conspicuously post the facility policy on charity care and the amount

1 spent by the facility on charity care during the preceding calendar year in the following
2 locations:

- 3 (1) On the licensed premises in an area accessible to the public.
- 4 (2) On an Internet Web site established and maintained by the ambulatory
5 surgical facility and made available to the general public."

6 **SECTION 7.** Not later than July 1, 2013, the Department of Health and Human
7 Services shall do all of the following:

- 8 (1) Communicate the requirements of Sections 3 and 4 of this act to all hospitals
9 licensed pursuant to Article 5 of Chapter 131E of the General Statutes.
- 10 (2) Communicate the requirements of Sections 3 and 6 of this act to all
11 ambulatory surgical facilities licensed pursuant to Part 4 of Article 6 of
12 Chapter 131E of the General Statutes.

13 **SECTION 8.** G.S. 131E-97.3(a) reads as rewritten:

14 **"§ 131E-97.3. Confidentiality of competitive health care information.**

15 (a) For the purposes of this section, competitive health care information means
16 information relating to competitive health care activities by or on behalf of hospitals and public
17 hospital authorities. Competitive health care information does not include any of the
18 information hospitals are required to report under G.S. 131E-91.1 or any of the information
19 ambulatory surgical facilities are required to report under G.S. 131E-153. Competitive health
20 care information shall be confidential and not a public record under Chapter 132 of the General
21 Statutes; provided that any contract entered into by or on behalf of a public hospital or public
22 hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise
23 exempted by law, or the contract contains competitive health care information, the
24 determination of which shall be as provided in subsection (b) of this section."

25 **SECTION 9.** G.S. 131E-99 reads as rewritten:

26 **"§ 131E-99. Confidentiality of health care contracts.**

27 The Except for the information a hospital is required to report under G.S. 131E-91.1 and the
28 information an ambulatory surgical facility is required to report under G.S. 131E-153, the
29 financial terms and other competitive health care information directly related to the financial
30 terms in a health care services contract between a hospital or a medical school and a managed
31 care organization, insurance company, employer, or other payer is confidential and not a public
32 record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an
33 elected public body which has responsibility for the hospital or medical school from having
34 access to this confidential information in a closed session. The disclosure to a public body does
35 not affect the confidentiality of the information. Members of the public body shall have a duty
36 not to further disclose the confidential information."

37 38 **PART III. TRANSPARENCY IN BILLING FOR OUTPATIENT RADIOLOGY** 39 **SERVICES**

40 **SECTION 10.** Part 4A of Article 5 of Chapter 131E of the General Statutes is
41 amended by adding a new section to read:

42 **"§ 131E-91.3. Duplicate charges for certain radiology services prohibited.**

43 (a) The following definitions apply in this section:

44 (1) Clinical labor. – Includes all of the following:

- 45 a. Greeting the patient.
- 46 b. Escorting and positioning the patient for radiology services.
- 47 c. Educating the patient about the radiology services to be performed
48 and obtaining the patient's informed consent for the services.
- 49 d. Retrieving the patient's prior examinations.
- 50 e. Setting up an intravenous line for the patient.
- 51 f. Preparing and cleaning the examination room.

g. Operating the radiology equipment.

(2) Multiple radiology session. – A single outpatient session during which multiple radiology imaging procedures are performed.

(3) Technical components. – The clinical labor and supplies used by a hospital to perform radiology imaging procedures on a patient, including gowns and contrast material. This term does not include X-ray film.

(b) It shall be unlawful for a hospital licensed under this Article, or a health care provider affiliated with the hospital, to charge a patient, entity, or person more than once for the full amount of the technical components of radiology imaging procedures performed on the patient during a multiple radiology session if the hospital or health care provider affiliated with the hospital only provides the technical components once during the multiple radiology session.

(c) Any contract provision or other agreement between a health insurer and a hospital licensed under this Article, or a health care provider affiliated with the hospital, that purports to require a party to pay for charges deemed unlawful under this section is void and unenforceable.

(d) Nothing in this section shall be construed to prohibit a hospital, or a health care provider affiliated with the hospital, from doing any of the following:

(1) Charging a patient, entity, or person for the full amount of the technical components of multiple radiology imaging procedures performed on the same day, but not during the same session.

(2) Submitting a corrected bill to a patient, entity, or person.

(3) Requesting the radiology services of more than one radiologist for a second medical opinion on a specimen."

SECTION 11. Part 4 of Article 6 of Chapter 131E. of the General Statutes is amended by adding a new section to read:

"§ 131E-153.3. Duplicate charges for certain radiology services prohibited.

(a) The following definitions apply in this section:

(1) Clinical labor. – Includes all of the following:

a. Greeting the patient.

b. Escorting and positioning the patient for radiology services.

c. Educating the patient about the radiology services to be performed and obtaining the patient's informed consent for the services.

d. Retrieving the patient's prior examinations.

e. Setting up an intravenous line for the patient.

f. Preparing and cleaning the examination room.

g. Operating the radiology equipment.

(2) Multiple radiology session. – A single outpatient session during which multiple radiology imaging procedures are performed.

(3) Technical components. – The clinical labor and supplies used by a hospital to perform radiology imaging procedures on a patient, including gowns and contrast material. This term does not include X-ray film.

(b) It shall be unlawful for an ambulatory surgical facility licensed under this Part, or a health care provider affiliated with the facility, to charge a patient, entity, or person more than once for the full amount of the technical components of radiology imaging procedures performed on the patient during a multiple radiology session if the ambulatory surgical facility or health care provider affiliated with the facility only provides the technical components once during the multiple radiology session.

(c) Any contract provision or other agreement between a health insurer and an ambulatory surgical facility licensed under this Part, or a health care provider affiliated with the facility, that purports to require a party to pay for charges deemed unlawful under this section is void and unenforceable.

(d) Nothing in this section shall be construed to prohibit an ambulatory surgical facility, or a health care provider affiliated with the facility, from doing any of the following:

- (1) Charging a patient, entity, or person for the full amount of the technical components of multiple radiology imaging procedures performed on the same day, but not during the same session.
- (2) Submitting a corrected bill to a patient, entity, or person.
- (3) Requesting the radiology services of more than one radiologist for a second medical opinion on a specimen."

PART IV. HOSPITAL DEBT COLLECTION

SECTION 12. G.S. 105A-2(9) reads as rewritten:

"(9) State agency. – Any of the following:

a. A unit of the executive, legislative, or judicial branch of State ~~government-government~~, except for the following:

1. Any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The University of North Carolina that provides medical care to the general public.
2. The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System.

b. A local agency, to the extent it administers a program supervised by the Department of Health and Human Services or it operates a Child Support Enforcement Program, enabled by Chapter 110, Article 9, and Title IV, Part D of the Social Security Act.

c. A community college."

PART V. HOSPITAL PROVIDER ASSESSMENTS

SECTION 13.(a) Article 7 of Chapter 108A of the General Statutes reads as rewritten:

"Article 7.

"Hospital Provider Assessment Act.

...

"§ 108A-121. Definitions.

The following definitions apply in this Article:

- (1) CMS. – Centers for Medicare and Medicaid Services.
- (2) Critical access hospital. – Defined in 42 C.F.R. § 400.202.
- (3) Department. – The Department of Health and Human Services.
- (4) Equity assessment. – The assessment payable under ~~G.S. 108A-123-G.S. 108A-123(b).~~
- (5) Federal Medicaid match rate. – The Federal Medical Assistance Percentage rate for North Carolina.
- (5) ~~Medicaid equity payment. – The amount required to be paid under G.S. 108A-124.~~
- (6) Public hospital. – A hospital that certifies its public expenditures to the Department pursuant to 42 C.F.R. § 433.51(b) during the fiscal year for which the assessment applies.
- (7) Secretary. – ~~The Secretary of Health and Human Services~~ the Department.
- (8) State's annual Medicaid payment. – ~~Forty-three million dollars (\$43,000,000).~~ The amount payable to the State under G.S. 108A-124(a)(1).

- 1 (9) State Medicaid match rate. – One hundred percent (100%) minus the Federal
2 Medicaid match rate.
3 ~~(9)~~(10) Total hospital costs. – The costs as calculated using the most recent available
4 Hospital Cost Report Information Systems cost report data, available
5 through CMS, or other comparable data.
6 ~~(10)~~(11) Upper pay limit (UPL). – The maximum ceiling imposed by federal
7 regulation on hospital Medicaid payments under 42 C.F.R. § 447.272 for
8 inpatient services.
9 ~~(11)~~(12) UPL assessment. – The assessment payable under
10 ~~G.S. 108A-123.~~G.S. 108A-123(c).
11 ~~(12)~~(13) UPL gap. – The difference between the UPL attributable to hospital
12 inpatient services and the reasonable costs of inpatient hospital services as
13 defined in Section (f)(2)(A) on page 11 of Attachment 4.19-A of the State
14 Medicaid Plan as approved on December 15, 2005.
15 ~~(13) UPL payment. The amount required to be paid under G.S. 108A-124.~~

16 **"§ 108A-122. Assessment.**

17 (a) Assessment Imposed. – Except as provided in this section, the assessments
18 authorized under this Article are imposed as a percentage of total hospital costs on all licensed
19 North Carolina hospitals. The assessments are due quarterly in the time and manner prescribed
20 by the Secretary. Payment of an assessment is considered delinquent if not paid within seven
21 days of the due date. With respect to any past-due assessment, the Department may withhold
22 the unpaid amount from Medicaid payments otherwise due or impose a late-payment penalty.
23 The Secretary may waive a penalty for good cause shown.

24 (b) Allowable Cost. – An assessment paid under this Article may be included as
25 allowable costs of a hospital for purposes of any applicable Medicaid reimbursement formula.
26 An assessment imposed under this Article may not be added as a surtax or assessment on a
27 patient's bill.

28 (c) Full Exemption. – The following hospitals are exempt from both the equity
29 assessment and the UPL assessment:

- 30 (1) State-owned and State-operated hospitals.
31 (2) The primary affiliated teaching hospital for each University of North
32 Carolina medical school.
33 (3) Critical access hospitals.
34 (4) Long-term care hospitals.
35 (5) Freestanding psychiatric hospitals.
36 (6) Freestanding rehabilitation hospitals.

37 (d) Partial Exemption. – A public hospital is exempt from the equity assessment.

38 (e) Assessment Collection. – Every assessment imposed by this Article shall become,
39 from the time it is due and payable, a debt from the hospital liable to pay the same to the State
40 of North Carolina. The Secretary of the Department of Health and Human Services shall report
41 overdue assessments to the Secretary of the Department of Revenue who shall collect the debt
42 using the collection remedies provided under Article 9 of Chapter 105 of the General Statutes.

43 **"§ 108A-123. Assessment amount.**

44 (a) Annual Calculation. – The Secretary must annually calculate the equity assessment
45 amount and the UPL assessment amount for each hospital subject to the respective assessment.
46 Each assessment must comply with applicable federal regulations and may be prorated for any
47 partial year. The Secretary must notify each hospital that is assessed the amount of its UPL
48 assessment and, if applicable, its equity assessment. The notice must include all of the
49 following:

- 50 (1) The applicable assessment rates.
51 (2) The hospital costs on which the hospital's assessments are based.

(3) The elements of the calculation of the hospital's UPL.

(b) Equity Assessment. – The equity assessment consists of both inpatient and outpatient components. The equity assessment percentage rate must be calculated to produce an aggregate annual amount equal to the sum of the following:

(1) ~~The amount needed to make the Medicaid equity payments under G.S. 108-124.~~ The State Medicaid match rate multiplied by the sum of Medicaid inpatient and outpatient deficits after calculating all other Medicaid payments, excluding disproportionate share hospital payments and any payments remitted to the hospitals under G.S. 108A-124(a)(2), for all hospitals subject to the equity assessment.

(2) ~~The applicable portion of the State's annual Medicaid payment, as additional amount provided in subsection (d) of this section.~~

(c) UPL Assessment. – The UPL assessment consists of both inpatient and outpatient components. The UPL assessment percentage rate must be calculated to produce an aggregate annual amount equal to the sum of the following:

(1) ~~The amount needed to make the UPL payments under G.S. 108A-124. The State Medicaid match rate multiplied by the sum of the UPL gaps for all hospitals subject to the UPL assessment.~~

(2) ~~The applicable portion of the State's annual Medicaid payment, as additional amount provided in subsection (d) of this section.~~

(d) ~~State's Annual Medicaid Payment. Additional Amount. – The State's annual Medicaid payment~~ The sum of forty-three million dollars (\$43,000,000) must be allocated between the equity assessment and the UPL assessment based on the amount of gross payments received by hospitals under G.S. 108A-124.

(e) Appeal. – A hospital may appeal an assessment determination through a reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation to pay an assessment amount when due.

(f) Assessment Limit. – Notwithstanding any other provision of this Article, the Secretary shall, if necessary, reduce a hospital's assessment so that the assessment does not exceed the percentage of gross revenue that would result in this Article imposing an impermissible health care-related tax, as defined under federal Medicaid law.

"§ 108A-124. Use of assessment proceeds.

(a) Use. – The proceeds of the assessments imposed under this Article and all corresponding matching federal funds must be used to make the State annual Medicaid payment to the State and ~~the Medicaid equity payments and UPL payments to hospitals.~~ hospitals as follows:

(1) Payment to State. – The sum of fifty million dollars (\$50,000,000) shall be transferred to the Controller.

(2) Payments to hospitals. – After making the payment under subdivision (1) of this subsection, the Secretary shall allocate the remaining proceeds to hospital providers with low average monthly total Medicaid costs.

(b) Quarterly Payments. – Within seven days of the due date for each quarterly assessment imposed under G.S. 108A-123, the Secretary must ~~do the following: transfer or pay twenty-five percent (25%) of the annual amounts provided in subsection (a) of this section to the respective payment recipients.~~

(1) ~~Transfer to the State Controller twenty five percent (25%) of the State's annual Medicaid payment amount.~~

(2) ~~Pay to each hospital that has paid its equity assessment for the respective quarter twenty five percent (25%) of its Medicaid equity payment amount. A hospital's Medicaid equity payment amount is the sum of the hospital's Medicaid inpatient and outpatient deficits after calculating all other~~

Medicaid payments, excluding disproportionate share hospital payments and the UPL payment remitted to the hospital under subdivision (3) of this subsection.

(3) Pay to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, to the critical access hospitals, and to each hospital that has paid its UPL assessment for the respective quarter twenty-five percent (25%) of its UPL payment amount, as determined under subsection (c) of this section.

(c) UPL Payment Amount. Restriction on Payments. – The aggregate UPL payments made to eligible hospitals that are public hospitals is the sum of the UPL gaps for all public hospitals. The aggregate UPL payments made to eligible hospitals that are not public hospitals is the sum of the UPL gaps for these hospitals. UPL payments are payable to the individual hospitals in the ratio of each hospital's Medicaid inpatient costs to the total Medicaid inpatient costs for the respective group. Quarterly payments shall only be made to a hospital that has paid its assessments for the respective quarter.

(d) Refund of Assessment. – If all or any part of a payment required to be made under this section is not made to one or more hospitals when due, a hospital within one month after the quarterly assessments are due, the Secretary must promptly refund to each such hospital the corresponding assessment proceeds collected in proportion to the amount of assessment paid by that hospital.

...."

SECTION 13.(b) Pursuant to G.S. 108A-126, the Department of Health and Human Services shall file a State plan amendment with the Centers for Medicare and Medicaid Services that incorporates the assessment payments and distributions consistent with the amendments to the provisions of Article 7 of Chapter 108A of the General Statutes made by this section.

SECTION 13.(c) The Secretary of the Department of Health and Human Services shall develop the payment methodology under G.S. 108A-124(a)(2), as enacted by this section, in conjunction with the Office of Budget and Management and North Carolina Community Care Networks, Inc. (CCNC). Prior to making any payments under G.S. 108A-124(a)(2), as enacted by this section, the Secretary of the Department of Health and Human Services shall consult with the Joint Legislative Commission on Governmental Operations; such consultation shall occur no later than October 1, 2013.

PART VI. COMMUNITY CARE OF NORTH CAROLINA GOVERNANCE

SECTION 14.(a) The Department of Health and Human Services may not enter into a contract with North Carolina Community Care Networks, Inc., (CCNC) unless CCNC has made the governance changes provided in subsection (b) of this section.

SECTION 14.(b) North Carolina Community Care Networks, Inc., is encouraged to make, as soon as practicable, the following governance changes by amending its articles of incorporation, amending its bylaws, or taking other appropriate action:

(1) Adjust the board so as to contain the following:

- a. A health actuary.
- b. Two representatives of the provider community.
- c. One representative of the health insurance industry.
- d. Someone with expertise in health information technology, informatics, or performance measurement.
- e. A business owner.

(2) Adjust the board so as to provide for the following additional members:

- a. The Director of the Division of Medical Assistance.

- 1 b. Two persons appointed by General Assembly on the
2 recommendation of the President Pro Tempore.
3 c. Two persons appointed by the General Assembly on the
4 recommendation of the Speaker of the House.
5 d. Two persons appointed by the Governor.
6 (3) Ensure that no members on its board directly benefit from the per member
7 per month (PMPM) payments to participating providers.
8 (4) Ensure that no more than twenty-five percent (25%) of the members of the
9 board are providers or come from the provider community.
10 (5) Ensure that the board size does not exceed 13 members.
11

12 **PART VII. EFFECTIVE DATE**

13 **SECTION 15.** Sections 8 and 9 of this act become effective January 1, 2014.
14 Sections 10 and 11 of this act become effective July 1, 2013, and apply to outpatient radiology
15 services provided, and contracts executed or renewed, on or after that date. Section 12 of this
16 act becomes effective January 1, 2014, and applies to tax refunds determined by the
17 Department of Revenue on or after that date. Section 13(a) of this act becomes effective July 1,
18 2013. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 473
PROPOSED COMMITTEE SUBSTITUTE S473-CSRF-9 [v.12]

4/23/2013 10:42:46 PM

Short Title: HealthCare Cost Reduction & Transparency.

(Public)

Sponsors:

Referred to:

March 28, 2013

A BILL TO BE ENTITLED
AN ACT TO IMPROVE TRANSPARENCY IN THE COST OF HEALTH CARE
PROVIDED BY HOSPITALS AND AMBULATORY SURGICAL FACILITIES; TO
TERMINATE SET-OFF DEBT COLLECTION BY CERTAIN STATE AGENCIES
PROVIDING HEALTH CARE TO THE PUBLIC; TO PROHIBIT HOSPITALS AND
AMBULATORY SURGICAL FACILITIES FROM CHARGING MULTIPLE TIMES
FOR OUTPATIENT RADIOLOGY SERVICES RENDERED ONLY ONCE; TO
PROVIDE FOR FAIR HEALTHCARE FACILITY BILLING AND COLLECTIONS
PRACTICES; AND TO ENCOURAGE COMMUNITY CARE OF NORTH CAROLINA
TO ADJUST ITS CORPORATE GOVERNANCE.

The General Assembly of North Carolina enacts:

PART I. TITLE

SECTION 1. This act shall be known as the Health Care Cost Reduction and
Transparency Act of 2013.

PART II. TRANSPARENCY IN HEALTH CARE COSTS

SECTION 2. G.S. 90-413.2 reads as rewritten:

"§ 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. This Article is also intended to improve transparency in
health care costs by providing information to the public on the cost of the 50 most common
episodes of care in hospitals subject to the North Carolina Hospital Licensure Act and
ambulatory surgical facilities subject to the North Carolina Ambulatory Surgical Facility
Licensure Act.

SECTION 3. Article 29A of Chapter 90 of the General Statutes is amended by
adding a new section to read:

"§ 90-413.9. Disclosure of prices for most common episodes of care.

(a) The NC HIE shall publish on its internet website available to the public in a
conspicuous manner the most current information it receives from hospitals and ambulatory
surgical facilities pursuant to G.S. 131E-91.1 and G.S. 131E-153. The NC HIE shall provide



1 this information in a manner that is easily understood by the public and meets the following
2 minimum requirements:

- 3 (1) Information for each hospital shall be listed separately, and hospitals shall be
4 listed in groups by category, as determined by the North Carolina Medical
5 Care Commission in rules adopted pursuant to G.S. 131E-91.1.
 - 6 (2) Information for each ambulatory surgical facility shall be listed separately.
 - 7 (3) Information concerning the most common episodes of care for each hospital
8 shall include a separate listing of the facility fees charged by health care
9 providers affiliated with the hospital.
 - 10 (4) Information concerning the most common episodes of care for each
11 ambulatory surgical facility shall include a separate listing of the facility fees
12 charged by health care providers affiliated with the facility.
- 13 (b) Any data disclosed to the North Carolina Health Information Exchange by a hospital or
14 ambulatory surgical facility pursuant to the Health Care Cost Reduction and Transparency Act of
15 2013 shall be and will remain the sole property of the facility that submitted the data. Any data
16 or product derived from the data disclosed to the NC HIE pursuant to the Health Care Cost
17 Reduction and Transparency Act of 2013, including a consolidation or analysis of the data,
18 shall be and will remain the sole property of the State. The NC HIE, North Carolina
19 Community Care Networks, Inc., (CCNC), and all other entities that directly or indirectly
20 receive any data disclosed to the NC HIE by a hospital or an ambulatory surgical facility
21 pursuant to the Health Care Cost Reduction and Transparency Act of 2013, or that are involved
22 in any other CCNC information technology initiative are prohibited from disclosing, selling, or
23 exchanging the data, or any consolidation, analysis, or product derived from the data, for a fee
24 or other consideration any of any kind.

25 **SECTION 4.** Article 5 of Chapter 131E of the General Statutes is amended by
26 adding a new Part to read:

27 "Part 4A. Transparency in Health Care Costs.

28 "**§ 131E-91.1. Disclosure of prices for most common episodes of care.**

29 (a) The following definitions apply in this section:

- 30 (1) Episode of care. – All acute care hospital services related to a health
31 condition with a given diagnosis, from the three-day period preceding a
32 patient's first admission to a hospital, including readmissions, through the
33 30-day period following the patient's discharge from the hospital, for
34 treatment of the health condition. The term includes acute care hospital
35 services, services by health care providers employed by the hospital, facility
36 use by health care providers affiliated with the hospital, ancillary services,
37 room and board, and pharmaceuticals dispensed by the hospital pharmacy or
38 by a pharmacy owned or controlled by, or under contract with, the hospital.
- 39 (2) Health insurer. – As defined in G.S. 108A-55.4, provided that "health
40 insurer" shall not include self-insured plans and group health plans as
41 defined in section 607(1) of the Employee Retirement Income Security Act
42 of 1974.
- 43 (3) Public or private third party. – Includes the State, the federal government,
44 employers, health insurers, third-party administrators, and managed care
45 organizations.

46 (b) Beginning on March 31, 2014 and quarterly thereafter, each hospital licensed
47 pursuant to this Article shall provide to the North Carolina Health Information Exchange,
48 utilizing electronic health records software, the following information about the 50 most
49 common episodes of care established by the Commission:

- 50 (1) The amount that will be charged to a patient for each episode of care if all
51 charges are paid in full without a public or private third party paying for any

1 portion of the charges, along with a separate listing of the facility fees
2 charged by health care providers affiliated with the hospital for each episode
3 of care.

4 (2) The average negotiated settlement on the amount that will be charged to a
5 patient required to be provided in subdivision (1) of this subsection.

6 (3) The total amount of Medicaid reimbursements for each episode of care,
7 including claims and pro rata supplemental payments.

8 (4) The total amount of Medicare reimbursements for each episode of care.

9 (5) For the five largest health insurers providing payment to the hospital on
10 behalf of insureds, the range of the total amount of payments made for each
11 episode of care. Prior to providing this information to the NC HIE, each
12 hospital shall redact the names of the health insurers and any other
13 information that would otherwise identify the health insurers.

14 (6) The total amount of payments made by the State Health Plan for Teachers
15 and State Employees for each episode of care.

16 (c) Upon request of a patient, a hospital shall provide the information required by
17 subsection (b) of this section to the patient, in writing, within 24 hours after receiving the
18 request.

19 (d) The disclosure requirements of this section shall not be construed to require a
20 hospital licensed pursuant to this Article to participate in the voluntary statewide health
21 information exchange network overseen and administered by the North Carolina Health
22 Information Exchange.

23 (e) The Commission shall adopt rules to ensure that this section is properly
24 implemented on January 1, 2014, and that hospitals report this information to the North
25 Carolina Health Information Exchange in a uniform manner. The rules shall include all of the
26 following:

27 (1) The 50 most common episodes of care on which the hospitals must report.
28 The Commission shall identify a cross section of medical and surgical
29 specialty areas from which to draw the 50 most common episodes of care.

30 (2) Specific categories by which hospitals shall be grouped for the purpose of
31 disclosing this information to the public on the NC HIE Internet web site."

32 **"§ 131E-91.2. Disclosure of uncompensated care, charity care and bad debt information.**

33 (a) The following definitions apply in this section:

34 (1) "Bad debt" is the cost of care provided for which a hospital expected, but
35 cannot obtain, reimbursement either because a patient is unable to pay the
36 bill but did not apply for charity care or because the patient was unwilling to
37 pay the bill.

38 (2) "Charity care" is the cost of care for which a hospital never expected
39 reimbursement because of a determination that the patient was unable to pay
40 for the services rendered.

41 (3) "Uncompensated care" is the total cost of care provided for which a hospital
42 did not receive payment

43 (b) Beginning on January 1, 2014 and annually thereafter, each operator of a hospital
44 shall conspicuously post the hospital policy on charity care, and the amounts spent by the
45 hospital on uncompensated care, charity care, and bad debt during the preceding calendar year,
46 in the following locations:

47 (1) On the licensed premises in an area accessible to the public.

48 (2) On an Internet Web site established and maintained by the hospital and made
49 available to the general public."

50 **SECTION 5.** Part 4 of Article 6 of Chapter 131E of the General Statutes is
51 amended by adding new sections to read:

"§ 131E-153. Disclosure of prices for most common episodes of care.

(a) The following definitions apply in this section:

(1) Episode of care. – All ambulatory surgical services related to a health condition with a given diagnosis, from the three-day period preceding a patient's first admission to an ambulatory surgical facility, including readmissions, through the seven-day period following the patient's discharge from the facility, for treatment of the health condition. The term includes ambulatory surgical services, services by health care providers employed by the facility, facility use by health care providers affiliated with the facility, use of facility operating and recovery rooms, and pharmaceuticals dispensed by the ambulatory surgical facility pharmacy or by a pharmacy owned or controlled by the ambulatory surgical facility.

(2) Health insurer. – As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(3) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning on March 31, 2014 and quarterly thereafter, each ambulatory surgical facility licensed pursuant to this Part shall provide to the North Carolina Health Information Exchange, utilizing electronic health records software, the following information about the facility's 50 most common episodes of care:

(1) The amount that will be charged to a patient for each episode of care if all charges are paid in full without a public or private third party paying for any portion of the charges, along with a separate listing of the facility fees charged by health care providers affiliated with the hospital for each episode of care.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The total amount of Medicaid reimbursements for each episode of care.

(4) The total amount of Medicare reimbursements for each episode of care.

(5) For the five largest health insurers providing payment to the facility on behalf of insureds, the range of the total amount of payments made for each episode of care. Prior to providing this information to the NC HIE, each facility shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

(6) The total amount of payments made by the State Health Plan for Teachers and State Employees for each episode of care.

(c) Upon request of a patient, an ambulatory surgical facility shall provide the information required by subsection (b) of this section to the patient, in writing, within 24 hours after receiving the request.

(d) The disclosure requirements of this section shall not be construed to require an ambulatory surgical facility licensed pursuant to this Part to participate in the voluntary statewide health information exchange network overseen and administered by the North Carolina Health Information Exchange.

(e) The Commission shall adopt rules to ensure that this section is properly implemented on January 1, 2014, and that ambulatory surgical facilities report this information to the North Carolina Health Information Exchange in a uniform manner. The rules shall include the 50 most common episodes of care on which the ambulatory surgical facilities must

report. The Commission shall identify a cross section of medical and surgical specialty areas from which to draw the 50 most common episodes of care."

"§ 131E-153.1. Disclosure of uncompensated care, charity care and bad debt information.

(a) The following definitions apply in this section:

(1) "Bad debt" is the cost of care provided for which an ambulatory surgical facility expected, but cannot obtain, reimbursement either because a patient is unable to pay the bill but did not apply for charity care or because the patient was unwilling to pay the bill.

(2) "Charity care" is the cost of care for which an ambulatory surgical facility never expected reimbursement because of a determination that the patient was unable to pay for the services rendered.

(3) "Uncompensated care" is the total cost of care provided for which an ambulatory surgical facility did not receive payment.

(b) Beginning on January 1, 2014 and annually thereafter, each operator of an ambulatory surgical facility shall conspicuously post the facility policy on charity care, and the amounts spent by the facility on uncompensated care, charity care, and bad debt during the preceding calendar year, in the following locations:

(1) On the licensed premises in an area accessible to the public.

(2) On an Internet Web site established and maintained by the ambulatory surgical facility and made available to the general public."

SECTION 6. Not later than July 1, 2013, the Department of Health and Human Services shall do all of the following:

(1) Communicate the requirements of Sections 3 and 4 of this act to all hospitals licensed pursuant to Article 5 of Chapter 131E of the General Statutes.

(2) Communicate the requirements of Sections 3 and 5 of this act to all ambulatory surgical facilities licensed pursuant to Part 4 of Article 6 of Chapter 131E of the General Statutes.

SECTION 7. G.S. 131E-97.3(a) reads as rewritten:

"§ 131E-97.3. Confidentiality of competitive health care information.

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of hospitals and public hospital authorities. Competitive health care information does not include any of the information hospitals are required to report under G.S. 131E-91.1 or any of the information ambulatory surgical facilities are required to report under G.S. 131E-153. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of a public hospital or public hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section."

SECTION 8. G.S. 131E-99 reads as rewritten:

"§ 131E-99. Confidentiality of health care contracts.

~~The~~ Except for the information a hospital is required to report under G.S. 131E-91.1 and the information an ambulatory surgical facility is required to report under G.S. 131E-153, the financial terms and other competitive health care information directly related to the financial terms in a health care services contract between a hospital or a medical school and a managed care organization, insurance company, employer, or other payer is confidential and not a public record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an elected public body which has responsibility for the hospital or medical school from having access to this confidential information in a closed session. The disclosure to a public body does not affect the confidentiality of the information. Members of the public body shall have a duty not to further disclose the confidential information."

PART III. TRANSPARENCY IN BILLING FOR OUTPATIENT RADIOLOGY SERVICES

SECTION 9. Article 5 of Chapter 131E of the General Statutes is amended by adding a new Part to read:

"Part 4B. Transparency in Billing for Outpatient Radiology Services.

"§ 131E-91.3. Duplicate charges for certain radiology services prohibited.

(a) The following definitions apply in this section:

(1) Clinical labor. – Includes all of the following:

- a. Greeting the patient.
- b. Escorting and positioning the patient for radiology services.
- c. Educating the patient about the radiology services to be performed and obtaining the patient's informed consent for the services.
- d. Retrieving the patient's prior examinations.
- e. Setting up an intravenous line for the patient.
- f. Preparing and cleaning the examination room.
- g. Operating the radiology equipment.

(2) Multiple radiology session. – A single outpatient session during which multiple radiology imaging procedures are performed.

(3) Provider of radiology services. – A hospital, an ambulatory surgical facility, a freestanding radiology services facility, or a physician's office, that provides outpatient radiology services.

(3) Technical components. – The clinical labor and supplies used by a hospital to perform radiology imaging procedures on a patient, including gowns and contrast material. This term does not include X-ray film.

(b) It shall be unlawful for a provider of radiology services to charge a patient, entity, or person more than 80% of the full amount of the technical components of an outpatient radiology imaging procedure for each subsequent radiograph performed on the patient during a multiple radiology session if the provider of radiology services only provides the technical components once during the multiple radiology session.

(c) Any contract provision or other agreement between a health insurer and a provider of radiology services that purports to require a party to pay for charges deemed unlawful under this section is void and unenforceable.

(d) Nothing in this section shall be construed to prohibit a provider of radiology services from doing any of the following:

- (1) Charging a patient, entity, or person for the full amount of the technical components of multiple radiology imaging procedures performed on the same day, but not during the same session.
- (2) Submitting a corrected bill to a patient, entity, or person.
- (3) Requesting the radiology services of more than one radiologist for a second medical opinion on a specimen."

PART IV. HOSPITAL DEBT COLLECTION

SECTION 10. G.S. 105A-2(9) reads as rewritten:

"(9) State agency. – Any of the following:

a. A unit of the executive, legislative, or judicial branch of State government-government, except for the following:

- 1. Any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The University of North Carolina that provides medical care to the general public.

2. The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System.
- b. A local agency, to the extent it administers a program supervised by the Department of Health and Human Services or it operates a Child Support Enforcement Program, enabled by Chapter 110, Article 9, and Title IV, Part D of the Social Security Act.
- c. A community college."

PART V. FAIR HEALTHCARE FACILITY BILLING AND COLLECTIONS PRACTICES.

SECTION 11.(a). G.S. 131E-91 reads as rewritten:

"§ 131E-91. ~~Itemized charges on discharged patient's bill~~ Fair billing and collections practices for hospitals and ambulatory surgical facilities.

(a) All hospitals and ambulatory surgical facilities licensed pursuant to this Chapter shall, upon request of the patient ~~within 30 days of discharge,~~ present an itemized list of charges to all discharged patients. Patient bills that are not itemized shall include notification to the patient in large, easy to read print, of the right to request, free of charge, an itemized bill. A patient may request an itemized list of charges at any time within three years after the date of discharge or so long as the hospital or ambulatory surgical facility, a collections agency, or another assignee of the hospital or ambulatory surgical facility asserts the patient has an obligation to pay the bill.

(b) All bills and invoices provided to the patient by a hospital or ambulatory surgical facility shall be written so as to be readily understandable by the patient. Where the use of medical codes and terms is unavoidable, clear and understandable definitions of those codes and terms shall be included in large and easy to read print.

(c) If a patient has overpaid the amount due to the hospital or ambulatory surgical facility, whether as the result of insurance coverage, patient error, healthcare facility billing error, or other cause, the hospital or ambulatory surgical facility shall provide the patient with a refund within 60 days of receiving notice of the overpayment.

(d) A hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer.

(e) Hospitals and ambulatory surgical facilities shall abide by the following reasonable collections practices:

- (1) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee during the pendency of a patient's application for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.
- (2) A hospital or ambulatory surgical facility shall provide a patient with a written notice that the patient's bill will be subject to collections activity at least 30 days prior to the referral being made.
- (3) A hospital or ambulatory surgical facility that contracts with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity.
- (4) A hospital or ambulatory surgical facility shall require a collections agency, entity, or other assignee to obtain the written consent of the hospital or

ambulatory surgical facility prior to the collections agency, entity, or other assignee filing a lawsuit to collect the debt.

- (5) A hospital or ambulatory surgical facility, or a contracted collections agency, entity, or other assignee of the hospital or ambulatory surgical facility, shall not use wage garnishment, a lien on a patient's primary residence, or otherwise force a sale of the patient's primary residence, as a means of collecting an unpaid bill.

(f) The Commission shall adopt rules to ensure that this section is properly ~~implemented~~ ~~implemented, and that patient bills which are not itemized include notification to the patient of his right to request an itemized bill.~~ The Department shall not issue ~~new~~ or renew a license under this Chapter ~~Article~~ unless the applicant has demonstrated that the requirements of this section are being met."

SECTION 11.(b). Part 4 of Article 6 of Chapter 131E of the General Statutes is amended to read:

"§ 131E-147.1. Fair billing and collections practices for ambulatory surgical facilities.

All ambulatory surgical facilities licensed under this Part shall be subject to the fair billing and collections practices set out in G.S. 131E-91."

SECTION 11.(c). G.S. 58-3-245 reads as rewritten:

"§ 58-3-245. Provider directories; directories; cost tools for insured.

(a) Every health benefit plan utilizing a provider network shall maintain a provider directory that includes a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. The health benefit plan shall ensure that a patient is provided accurate and current information on each provider's network status through the telephone system and any electronic or online system. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory listing may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each directory listing shall include the following network information:

- (1) The provider's name, address, telephone number, and, if applicable, area of specialty.
- (2) Whether the provider may be selected as a primary care provider.
- (3) To the extent known to the health benefit plan, an indication of whether the provider:
 - a. Is or is not currently accepting new patients.
 - b. Has any other restrictions that would limit an insured's access to that provider.

(c) The directory listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified consistent with the requirements for the type of information required to be verified under G.S. 58-3-230.

(d) A healthcare provider shall provide to a patient or prospective patient, upon request, information on that provider's network status with a particular health benefit plan."

PART VI. COMMUNITY CARE OF NORTH CAROLINA GOVERNANCE

SECTION 12.(a) The Department of Health and Human Services may not enter into a contract with North Carolina Community Care Networks, Inc., (CCNC) unless CCNC has made the governance changes provided in subsection (b) of this section.

SECTION 12.(b) North Carolina Community Care Networks, Inc., is encouraged to make, as soon as practicable, the following governance changes by amending its articles of incorporation, amending its bylaws, or taking other appropriate action:

(1) Adjust the board so as to contain the following:

- a. A health actuary.
- b. Two representatives of the provider community.
- c. One representative of the health insurance industry.
- d. Someone with expertise in health information technology, informatics, or performance measurement.
- e. A business owner or their designee.

(2) Adjust the board so as to provide for the following additional members:

- a. Two persons appointed by General Assembly on the recommendation of the President Pro Tempore of the Senate at least one of whom shall be a business owner or their designee.
- b. Two persons appointed by the General Assembly on the recommendation of the Speaker of the House of Representatives at least one of whom shall be a business owner or their designee.
- d. Two persons appointed by the Governor at least one of whom shall be a business owner or their designee.

(3) Ensure that no more than 2 members on its board directly benefit from the per member per month (PMPM) payments to participating providers.

(4) Ensure that no more than twenty-five percent (25%) of the members of the board are providers or come from the provider community.

(5) Ensure that no member or immediate family of a member is a registered lobbyist or is employed by an entity that lobbies on behalf of a health care provider association.

(6) Ensure that the board size does not exceed 13 members.

PART VII. EFFECTIVE DATE

SECTION 13. Sections 7 and 8 of this act become effective January 1, 2014. Section 9 of this act becomes effective July 1, 2013, and applies to outpatient radiology services provided, and contracts executed or renewed, on or after that date. Section 10 of this act becomes effective January 1, 2014, and applies to tax refunds determined by the Department of Revenue on or after that date. Section 11 of this act becomes effective October 1, 2013. The remainder of this act is effective when it becomes law.



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 473

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

Page 1 of 1

S473-ARF-1 [v.1]

Comm. Sub. [YES]
Amends Title [YES]
First Edition

Date 24 April, 2013

Senator Hartsell

1 moves to amend the bill on page 1, lines 4-5 by rewriting those lines to read:

2
3 "PROHIBIT HOSPITALS AND" ;

4
5 And further amends the bill on page 6, line 43 through page 7, line 9, by deleting those lines.

SIGNED

Hutchinson Hartsell
Amendment Sponsor

SIGNED

Raffa E. H. d.
Committee Chair if Senate Committee Amendment

ADOPTED _____

FAILED X

TABLED _____



* S 4 7 3 - A R F - 1 - V - 1 *

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/24/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Stephen Kouben	compass inc
Dwain Harrison	NCNA
Mark Fleming	BCBSNC
Maureen Gardner	GSC
Elizabeth Robinson	NCRMA
Kara Weislaun	SA
Michelle Brooks	East Carolina University
Marie Wilder	No vant Health
DANIEL VANLIERE	VIDANT HEALTH
DOUG HERON	Williams Mullen
Matthew McConnell	Carolina's Healthcare
Sarah Sord	NP
B Miller	Care Health
E Nelson	NCHA
Jim Swann	Fresenius Medical Care-NA
Keith Monte	Fresenius Medical Care-NA
George Smith	NP

TJ Bugbee

NP

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/24/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
David Hemen	NC Center for Nonprofit
Fred Bone	Bone - Asso.
Andy Ellen	NCRMA
Adam Sholar	DHHS
Christine Craig	WakeMed
Hugh Tilson	Nura
Cory Harro	NCHA
Tim Wu	Hulu
Rowena Timms	Mission Health
Allison Waller	Nelson Mullins
Scott Laster	SS6NC
Kristen Laster	SS6NC
W. Chen	BCI
Gene Ainsworth	A & A

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/24/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Alex Badger	CSS
Daniel Baum	Thourman Sanders
Peppin Mm	NCMS
Chrocutt	NCMS
Chris Byssat	NCMS
h R	CCWC
JOE LANLIER	NELSON MULLINS
Amy Whitel	NCMS
Dana Sips	SAT
John T. Bode	BCS
Mike Heaven	NC DOJ
J Peren	NCDOJ
TRAVIS FAIR	Gboro News + Record
Joseph NERE	NJO
Tom Hefner	FSP
John Michel	Benchmark
Jaime Amoro	FSP

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/24/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Colleen Kocharek	NCCFP
SN Spinner	NCACC
Whitney Tronka	NCACC
Kay Pakson	NASW-WC
Chyn Vaughan	AstraZeneca
Phyllis S. Chi	D. C. & Co.
Sarah Wolfe	MMCLL
Henry Nicholson	UNC Hc
Andrew Blackburn	SSG NC
Jacob Yarnall	Sgt Brown
Susan Vick	FSP
Kevin Anderson	AG's office
AIMÉE ESCUETA	AG'S OFFICE
Chuck Stone	SEAR
Petey Ketter	American Heart Assn
Sam Smith	American Heart Assn
Tom Friedman	DST

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

4/24/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
May D. ...	AARP NC
Ken Bolton	LCA
JAKE PARKER	NCFB
Chris Aguer	DOJ
Scott Kyle	The ...
James ...	CSS
Jeff Tindall	
AMT ...	NMRS

**Senate Committee on Health Care
Wednesday, May 1, 2013
11:00 am
Room 544**

Senator Louis Pate Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages & Sergeants-at-Arms

Bills:

BILL NO.	SHORT TITLE	SPONSOR
SB 557	Amend Report Date/NC Pre-K Funding Pilot	Senator Hise
SB 486	Pertussis Education & Awareness	Senator Tarte Senator Pate Senator Hise
SB 488	Amend Nursing Home Administrator Act/Fees	Senator Tucker
SB 553	LME/MCO Enrollee Grievances & Appeals	Senator Hise
SB 530	Prohibit E-Cigarette Sales to Minors	Senator Goolsby

Adjournment

**Senate Committee on Health Care
Wednesday, May 1, 2013 at 11:00 am
Room 544**

MINUTES

The Senate Committee on Health Care met at 11:00 am on Wednesday, May 1, 2013 in Room 544. Eighteen members were present.

Senator Louis Pate presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Ashley Mickens, Steve Wilson, Ed Kesler, Donna Blake and Billy Fritscher. He then recognized the Pages assisting with the meeting: Rae Quawn Anderson from Wilson County and Odom Williford of Orange County.

Senator Pate recognized Senator Hise to explain the first bill on the agenda, SB 557 "Amend Report Date/NC Pre-K Funding Pilot." At the end of Senator Hise's explanation, Senator Wade moved for a favorable report; the motion carried.

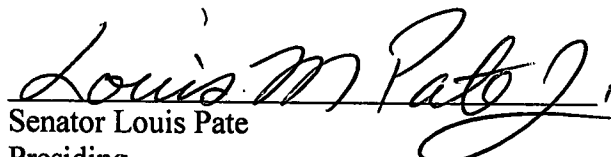
Next Senator Pate recognized Senator Tarte to explain SB 486 "Pertussis Education & Awareness." Senator Jim Davis moved for a favorable report; the motion carried.

Senator Tucker was then called on to explain SB 488 "Amend Nursing Home Administrator Act/Fees." A PCS was offered; Senator Wade moved to accept the PCS for consideration. Senator Tucker entertained several questions and entered an amendment to the PCS. Senator McKissick moved for a favorable report to the amended PCS with an unfavorable report as to the original bill and re-referred to Finance. The motion carried.

Senator Hise was recognized to explain SB 553 "LME/MCO Enrollee Grievances & Appeals." A PCS was offered; Senator Randleman entered a motion to accept the PCS for discussion. After numerous questions, Senator Randleman moved for a favorable report to the PCS with unfavorable to the original bill, and re-referred to Judiciary II; motion carried.

Senator Goolsby was then recognized to explain SB 530 "Prohibit E. Cigarette Sales to Minors." A PCS was offered and accepted by Senator Wade. After some discussion, Senator Hartsell moved for a favorable report to the PCS, unfavorable to the original bill with a serial referral to the Judiciary I Committee.

The meeting adjourned at 11:55 a.m.


Senator Louis Pate
Presiding


Edna Pearce, Committee Clerk

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

**HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair**

Wednesday, May 01, 2013

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

FAVORABLE

SB 486

Pertussis Education & Awareness.

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

SB 557

Amend Report Date/NC Pre-K Funding Pilot.

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

TOTAL REPORTED: 2

Senator Jeffery Tarte will handle SB 486
Senator Ralph Hise will handle SB 557



* C M R 4 4 O - V - 1 *

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Thursday, May 02, 2013

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

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

SB 488

Amend Nursing Home Administrator Act/Fees:

Draft Number: S488-PCS75304-RF-16

Sequential Referral: Finance

Recommended Referral: None

Long Title Amended: No

SB 530

Prohibit E-Cigarette Sales to Minors.

Draft Number: S530-PCS85216-TK-24

Sequential Referral: None

Recommended Referral: Judiciary I

Long Title Amended: No

SB 553

LME/MCO Enrollee Grievances & Appeals.

Draft Number: S553-PCS35336-SH-13

Sequential Referral: Judiciary II

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 3

Senator Tommy Tucker will handle SB 488
Senator Thomas Goolsby will handle SB 530
Senator Ralph Hise will handle SB 553



* C M R 4 5 2 - V - 1 *

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

1

SENATE BILL 557

Short Title: Amend Report Date/NC Pre-K Funding Pilot. (Public)

Sponsors: Senator Hise (Primary Sponsor).

Referred to: Education/Higher Education.

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO AMEND THE DATE THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES, DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION, IS
TO REPORT ON A PILOT PROGRAM FOR FUNDING OF THE NC
PREKINDERGARTEN PROGRAM.

The General Assembly of North Carolina enacts:

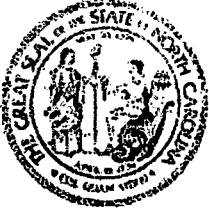
SECTION 1. Section 10.1(b) of S.L. 2012-142 reads as rewritten:

"SECTION 10.1.(b) The Division of Child Development and Early Education (Division) shall create a pilot program that provides funding for NC Pre-K classrooms on a per classroom basis. The pilot program shall include three different NC Pre-K contractual regions that are geographically diverse. The local NC Pre-K administrator shall contract with the provider for operation of a classroom established pursuant to the pilot program. The Division shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations/Base Budget Committee on Health and Human Services, and the Fiscal Research Division on the pilot program no later than January 31, 2013-2014. The report shall include the following:

- (1) The number of students served.
- (2) The amount of funds paid for each classroom.
- (3) The amount of funds paid per student.
- (4) The attendance information on students in the pilot program as compared to those students in a classroom having a traditional funding structure.
- (5) Information on the number of students and students' families using the Subsidized Early Education for Kids (SEEK) system.
- (6) A cost comparison of the classroom pilots to the average cost per student through the per student funding methodology."

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





SENATE BILL 557: Amend Report Date/NC Pre-K Funding Pilot

2013-2014 General Assembly

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

Date: April 29, 2013
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: Senate Bill 557 changes the reporting date on the pilot program created in S.L. 2012-143 regarding the provision of funding for NC Pre-K classrooms on a per classroom basis to Jan 31, 2014.

CURRENT LAW:

Section 10.1(b) of Session Law 2012-142 requires the Division of Child Development and Early Education (Division) to create a pilot program that provides funding for NC Pre-K classrooms on a per classroom basis. The Division was required to report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations/Base Budget Committee on Health and Human Services, and the Fiscal Research Division on the pilot program no later than January 31, 2013.

The report was to include:

- The number of students served.
- The amount of funds paid for each classroom.
- The amount of funds paid per student.
- The attendance information on students in the pilot program as compared to those students in a classroom having a traditional funding structure.
- Information on the number of students and students' families using the Subsidized Early Education for Kids (SEEK) system.
- A cost comparison of the classroom pilots to the average cost per student through the per student funding methodology.

BILL ANALYSIS: Senate Bill 557 changes the date the report is due to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations/Base Budget Committee on Health and Human Services, and the Fiscal Research Division from January 31, 2013, to January 31, 2014.

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

O. Walker Reagan
Director



Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 486

Short Title: Pertussis Education & Awareness.

(Public)

Sponsors: Senators Tarte, Pate, and Hise (Primary Sponsors).

Referred to: Health Care.

March 28, 2013

A BILL TO BE ENTITLED
AN ACT REQUIRING HOSPITALS TO PROVIDE PARENTS OF NEWBORNS WITH
EDUCATIONAL INFORMATION ABOUT PERTUSSIS DISEASE AND AVAILABLE
VACCINE PROTECTIONS IN ORDER TO BETTER PROTECT NEWBORNS
AGAINST PERTUSSIS DISEASE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 5 of Chapter 131E of the General Statutes is amended by
adding a new section to read:

"§ 131E-79.2. Educating parents of newborns regarding pertussis disease.

(a) Each hospital licensed under this Article shall provide to the parents of newborns delivered at the hospital free, medically accurate educational information about pertussis disease and the availability of the tetanus-diphtheria and pertussis (Tdap) vaccine to protect against pertussis disease. The hospitals shall provide this educational information to parents during the postpartum period and prior to the mother's discharge from the hospital. As used in this section, "postpartum period" means the period of time between the mother's admittance to the hospital for delivery of the newborn child through the first few hours after childbirth.

(b) The educational information provided to parents pursuant to this section shall include, at a minimum, the most current recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices regarding the use of tetanus-toxoid-diphtheria-acellular pertussis (Tdap) vaccine to reduce the burden of pertussis in infants.

(c) Nothing in this section shall be construed to require a hospital to provide or pay for any vaccination against pertussis disease."

SECTION 2. This act becomes effective October 1, 2013.





SENATE BILL 486: Pertussis Education & Awareness

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Tarte, Pate, Hise
Analysis of: First Edition

Date: April 30, 2013
Prepared by: Barbara Riley
Committee Counsel

SUMMARY:

Senate Bill 486 adds a new section, G.S. 131E-79.2, to the Hospital Licensure Act requiring each hospital to provide parents of newborns delivered at the hospital information about pertussis disease and the availability of the tetanus-diphtheria and pertussis (Tdap) vaccine. The hospital must provide this information during the postpartum period and prior to the mother's discharge.

The education information must include the most current recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices regarding the use of the Tdap vaccine to reduce the burden of pertussis in infants.

The requirements of the section shall not be construed to require a hospital to provide or pay for vaccinations against pertussis.

EFFECTIVE DATE:

The act becomes effective October 1, 2013.

Amy Jo Johnson, counsel to Senate Health Care, substantially contributed to this summary.

O. Walker Reagan
Director



Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 488

Short Title: Amend Nursing Home Administrator Act/Fees.

(Public)

Sponsors: Senator Tucker (Primary Sponsor).

Referred to: Health Care.

March 28, 2013

A BILL TO BE ENTITLED

AN ACT TO AMEND THE NURSING HOME ADMINISTRATOR ACT AND TO
INCREASE CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-278(1) reads as rewritten:

"§ 90-278. Qualifications for licensure.

The Board shall have authority to issue licenses to qualified persons as nursing home administrators, and shall establish qualification criteria for such nursing home administrators.

(1) A license as a nursing home administrator shall be issued to any person upon the Board's determination that:

- a. He is at least 18 years of age, of good moral character and of sound physical and mental health; and
- b. He has ~~successfully completed the equivalent of two years of college level study (60 semester hours or 96 quarter hours) from an accredited community college, college or university prior to application for licensure;~~
or
~~has completed a combination of education and experience, acceptable under rules promulgated by the Board, prior to application for licensure. Under this provision, two years of supervisory experience in a nursing home shall be equated to one year of college study; and~~been awarded a minimum of a baccalaureate degree from a college or university accredited by an agency recognized by the United States Department of Education, or an associate's degree in nursing with a minimum of five years of experience as a director of nursing for five of the previous six years prior to application for licensure.
- c. He has satisfactorily completed a course prescribed by the Board, which course contains instruction on the services provided by nursing homes, laws governing nursing homes, protection of patient interests and nursing home administration; and
- d. He has successfully completed his training period as an administrator-in-training as prescribed by the Board. If a person has served at least 12 weeks as a hospital administrator or assistant administrator of a hospital-based long-term care nursing unit or hospital-based swing beds licensed under Article 5 of Chapter 131E



* S 4 8 8 - V - 1 *

or Article 2 of Chapter 122C, the Board shall consider this experience comparable to the initial on-the-job portion of the administrator-in-training program only; and

- e. He has passed ~~examinations administered by the Board and designed to test for competence in the subject matters referred to in paragraph e of this subdivision.~~ the national and State examinations designed to test for competence in the subject matters referred to in sub-subdivision c. of this subdivision within one year from the date of completion of the administrator-in-training program.

...."

SECTION 2. G.S. 90-280 reads as rewritten:

"§ 90-280. Fees; display of license; duplicate license; inactive list.

(a) Each applicant for an examination administered by the Board and each applicant for an administrator-in-training program and reciprocity endorsement shall pay a processing fee set by the Board not to exceed ~~one hundred dollars (\$100.00)~~ five hundred dollars (\$500.00) plus the actual cost of the exam.

(b) Each person licensed as a nursing home administrator shall be required to pay a license fee in an amount set by the Board not to exceed ~~five hundred dollars (\$500.00)~~ one thousand dollars (\$1,000). A license shall expire on the thirtieth day of September of the second year following its issuance and shall be renewable biennially upon payment of a renewal fee set by the Board not to exceed ~~five hundred dollars (\$500.00)~~ one thousand dollars (\$1,000).

(c) Each person licensed as a nursing home administrator shall display his license certificate, along with the current certificate of renewal, in a conspicuous place in his place of employment.

(d) Any person licensed as a nursing home administrator may receive a duplicate license or verification of license by payment of a fee set by the Board not to exceed ~~twenty-five dollars (\$25.00)~~ one hundred dollars (\$100.00).

(e) Any person licensed as a nursing home administrator who is not acting, serving, or holding himself out to be a nursing home administrator may have his name placed on an inactive list for such period of time not to exceed four years upon payment of a fee set by the Board not to exceed ~~fifty dollars (\$50.00)~~ two hundred dollars (\$200.00) per year. Each year during that four-year period, upon request and payment of the fee, the person's name may remain on an inactive list for one additional year.

(f) Any person having a temporary license issued pursuant to G.S. 90-278(3) shall pay a fee in an amount set by the Board not to exceed ~~two hundred dollars (\$200.00)~~ five hundred dollars (\$500.00). If the Board renews the temporary license, no further fee shall be required.

(g) The Board may set fees not to exceed ~~two hundred and fifty dollars (\$250.00)~~ one thousand dollars (\$1,000) for conducting and administering initial training and continuing education courses, and may set a fee not to exceed one hundred dollars (\$100.00) per hour for certifying a course submitted for review by another individual or agency wishing to offer such courses or may set an annual fee not to exceed ~~two thousand dollars (\$2,000)~~ four thousand dollars (\$4,000) for certifying a course provider in lieu of certifying each course offered by the provider."

SECTION 3. G.S. 90-283 reads as rewritten:

"§ 90-283. Organization of Board; compensation; employees and services.

The Board shall elect from its membership a chairman, vice-chairman and secretary, and shall adopt rules and regulations to govern its proceedings. Board members shall be entitled to receive only such compensation and reimbursement as is prescribed by Chapter 93B of the General Statutes for State boards generally. At any meeting a majority of the voting members shall constitute a quorum. The Board ~~may employ any necessary personnel to assist it in the~~

1 ~~performance of its duties and may contract for such services as may be~~ shall have the power to
2 employ or retain professional personnel, including legal counsel subject to G.S. 114-2.3, and
3 clerical or other special personnel deemed necessary to carry out the provisions of this Article."

4 **SECTION 4. G.S. 90-285(3) reads as rewritten:**

5 **"§ 90-285. Functions and duties of the Board.**

6 The Board shall meet at least once annually in Raleigh or any other location designated by
7 the chairman and shall have the following functions and duties:

- 8 ...
9 (3) Issue licenses to qualified ~~individuals~~ individuals consistent with
10 G.S. 90-278 and G.S. 90-287 and any rules adopted by the Board
11 implementing those provisions.
12"

13 **SECTION 5. G.S. 90-285.1 reads as rewritten:**

14 **"§ 90-285.1. Suspension, revocation or refusal to issue a license.**

15 The Board may suspend, revoke, or refuse to issue a license or may reprimand or otherwise
16 discipline a licensee after due notice and an opportunity to be heard at a formal hearing, upon
17 substantial evidence that a licensee:

- 18 (1) Has violated the provisions of this Article or the rules adopted by the Board;
19 (2) Has violated the provisions of Part 2 of Article 6 of Chapter 131E of the
20 General Statutes and rules promulgated thereunder;
21 (3) Has been convicted of, or has tendered and has had accepted a plea of no
22 contest to, a criminal offense showing professional unfitness;
23 (4) Has practiced fraud, deceit, or misrepresentation in securing or procuring a
24 nursing home administrator license;
25 (5) Is incompetent to engage in the practice of nursing home administration or to
26 act as a nursing home administrator;
27 (6) Has practiced fraud, deceit, or misrepresentation in his capacity as a nursing
28 home administrator;
29 (7) Has committed acts of misconduct in the operation of a nursing home under
30 his jurisdiction;
31 ~~(8) Is a habitual drunkard;~~
32 (9) Is addicted or dependent upon the use of any controlled substance, including,
33 but not limited to, morphine, opium, cocaine, alcohol, or other drugs
34 recognized as resulting in abnormal behavior;
35 (10) Has practiced without being registered biennially;
36 (11) Has transferred or surrendered possession of, either temporarily or
37 permanently, his license or certificate to any other person;
38 (12) Has paid, given, has caused to be paid or given or offered to pay or to give to
39 any person a commission or other valuable consideration for the solicitation
40 or procurement, either directly or indirectly, of nursing home patronage;
41 (13) Has been guilty of fraudulent, misleading, or deceptive advertising;
42 (14) Has falsely impersonated another licensee;
43 (15) Has failed to exercise regard for the safety, health or life of the patient;
44 (16) Has permitted unauthorized disclosure of information relating to a patient or
45 his records; or
46 (17) Has discriminated among patients, employees, or staff on account of race,
47 ~~sex, gender, religion, color, or national origin~~ national origin, mental or
48 physical disability, or any other class protected by State or federal law."

49 **SECTION 6. G.S. 90-287 reads as rewritten:**

50 **"§ 90-287. Reciprocity with other states.**

1 The Board may issue a nursing home administrator's ~~license, without examination, license~~
2 to any person who holds a current license as a nursing home administrator from another
3 jurisdiction, provided that the Board finds that the standards for licensure in such other
4 jurisdiction are at least the substantial equivalent of those prevailing in this ~~State, State~~ and that
5 the applicant has passed the national and the State examinations administered by the Board and
6 is otherwise qualified."

7 **SECTION 7.** G.S. 90-288.01 reads as rewritten:

8 **"§ 90-288.01. Criminal history record checks of applicants for licensure.**

9 (a) The following definitions apply in this section:

10 (1) Applicant. — A person applying for initial licensure pursuant to either
11 G.S. 90-278 or G.S. 90-287 or applying for renewal of licensure pursuant to
12 G.S. 90-286.

13 (2) Criminal history. — A history of conviction of a state or federal crime,
14 whether a misdemeanor or felony, that bears on an applicant's fitness for
15 licensure as a nursing home administrator. The crimes include the criminal
16 offenses set forth in any of the following Articles of Chapter 14 of the
17 General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes;
18 Article 5A, Endangering ~~Executive and Legislative~~ Executive, Legislative,
19 and Court Officers; Article 6, Homicide; Article 7A, Rape and Other Sex
20 Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article
21 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device
22 or Material; Article 14, Burglary and Other Housebreakings; Article 15,
23 Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article
24 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A,
25 Obtaining Property or Services by False or Fraudulent Use of Credit Device
26 or Other Means; Article 19B, Financial Transaction Card Crime Act; Article
27 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public
28 Morality and Decency; Article 26A, Adult Establishments; Article 27,
29 Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct
30 in Public Office; Article 35, Offenses Against the Public Peace; Article 36A,
31 Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors;
32 Article 40, Protection of the Family; Article 59, Public Intoxication; and
33 Article 60, Computer-Related Crime. The crimes also include possession or
34 sale of drugs in violation of the North Carolina Controlled Substances Act,
35 Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses,
36 including sale to underage persons in violation of G.S. 18B-302 or driving
37 while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

38 (b) Criminal History Record Check. — The Board shall require a criminal history
39 record check of all ~~applicants~~ applicants for initial licensure and temporary licensure. The
40 Board, in its discretion, may require a criminal history record check of an applicant for license
41 renewal. Refusal to consent to a criminal history record check may constitute grounds for the
42 Board to deny licensure to an applicant. The Board shall provide to the North Carolina
43 Department of Justice the fingerprints of the applicant to be checked, a form signed by the
44 applicant consenting to the criminal history record check and the use of fingerprints and other
45 identifying information required by the State or National Repositories, and any additional
46 information required by the Department of Justice. The Board shall keep all information
47 obtained pursuant to this section confidential. The Board shall collect any fees required by the
48 Department of Justice and shall remit the fees to the Department of Justice for expenses
49 associated with conducting the criminal history record check.

50 (c) Convictions. — If the applicant's criminal history record check reveals one or more
51 convictions listed under subdivision (2) of subsection (a) of this section, the conviction shall

not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

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

(d) Denial of Licensure. — ~~If Except as otherwise provided by law, if the Board refuses to issue or renew a license based on information obtained in a criminal history record check, the Board must disclose to the applicant the information contained in the criminal history record check that is relevant to the Board's actions. The Board shall not provide a copy of the criminal history record check to the applicant. An applicant has the right to appear before the Board to appeal the Board's decision. An appearance before the Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.~~

(e) Limited Immunity. — The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for its actions based on information provided in an applicant's criminal history record check."

SECTION 8. Article 20 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"§ 90-288.02. Confidentiality of investigative records.

Records, papers, and other documents containing information collected and compiled by or on behalf of the Board as a result of an investigation, inquiry, or interview conducted in connection with certification, licensure, or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes. Any notice or statement of charges, notice of hearing, or decision rendered in connection with a hearing shall be a public record. Information that identifies a resident who has not consented to the public disclosure of services rendered to him or her by a person certified or licensed under this Chapter shall be deleted from the public record. All other records, papers, and documents containing information collected and compiled by or on behalf of the Board shall be public records, but any information that identifies a resident who has not consented to the public disclosure of services rendered to him or her shall be deleted."

SECTION 9. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 488
PROPOSED COMMITTEE SUBSTITUTE S488-CSRF-16 [v.2]

4/30/2013 9:22:35 PM

Short Title: Amend Nursing Home Administrator Act/Fees.

(Public)

Sponsors:

Referred to:

March 28, 2013

A BILL TO BE ENTITLED
AN ACT TO AMEND THE NURSING HOME ADMINISTRATOR ACT AND TO
INCREASE CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-278(1) reads as rewritten:

"§ 90-278. Qualifications for licensure.

The Board shall have authority to issue licenses to qualified persons as nursing home administrators, and shall establish qualification criteria for such nursing home administrators.

(1) A license as a nursing home administrator shall be issued to any person upon the Board's determination ~~that:~~ that the person:

- a. ~~He is~~ Is at least 18 years of age, of good moral character and of sound physical and mental health; and
- b. ~~He has~~ Has ~~successfully completed the equivalent of two years of college level study (60 semester hours or 96 quarter hours) from an accredited community college, college or university prior to application for licensure;~~
~~or~~
~~has completed a combination of education and experience, acceptable under rules promulgated by the Board, prior to application for licensure. Under this provision, two years of supervisory experience in a nursing home shall be equated to one year of college study; and been awarded a minimum of a baccalaureate degree from a college or university accredited by an agency recognized by the United States Department of Education, or an associate's degree in nursing with a minimum of five years of experience as a director of nursing for five of the previous six years prior to application for licensure.~~
- c. ~~He has~~ Has satisfactorily completed a course prescribed by the Board, which course contains instruction on the services provided by nursing homes, laws governing nursing homes, protection of patient interests and nursing home administration; and
- d. ~~He has~~ Has successfully completed ~~his~~ the training period as an administrator-in-training as prescribed by the Board. If a person has served at least 12 weeks as a hospital administrator or assistant administrator of a hospital-based long-term care nursing unit or hospital-based swing beds licensed under Article 5 of Chapter 131E



* S 4 8 8 - C S R F - 1 6 - V - 2 *

or Article 2 of Chapter 122C, the Board shall consider this experience comparable to the initial on-the-job portion of the administrator-in-training program only; and

- e. He has passed ~~examinations administered by the Board and designed to test for competence in the subject matters referred to in paragraph e of this subdivision~~ the national and State examinations designed to test for competence in the subject matters referred to in sub-subdivision c. of this subdivision within one year from the date of completion of the administrator-in-training program.

...."

SECTION 2. G.S. 90-280 reads as rewritten:

"§ 90-280. Fees; display of license; duplicate license; inactive list.

(a) Each applicant for an examination administered by the Board and each applicant for an administrator-in-training program and reciprocity endorsement shall pay a processing fee set by the Board not to exceed ~~one hundred dollars (\$100.00)~~ five hundred dollars (\$500.00) plus the actual cost of the exam.

(b) Each person licensed as a nursing home administrator shall be required to pay a license fee in an amount set by the Board not to exceed ~~five hundred dollars (\$500.00)~~ one thousand dollars (\$1,000). A license shall expire on the thirtieth day of September of the second year following its issuance and shall be renewable biennially upon payment of a renewal fee set by the Board not to exceed ~~five hundred dollars (\$500.00)~~ one thousand dollars (\$1,000).

(c) Each person licensed as a nursing home administrator shall display his license certificate, along with the current certificate of renewal, in a conspicuous place in his place of employment.

(d) Any person licensed as a nursing home administrator may receive a duplicate license or verification of license by payment of a fee set by the Board not to exceed ~~twenty-five dollars (\$25.00)~~ one hundred dollars (\$100.00).

(e) Any person licensed as a nursing home administrator who is not acting, serving, or holding himself out to be a nursing home administrator may have his name placed on an inactive list for such period of time not to exceed four years upon payment of a fee set by the Board not to exceed ~~fifty dollars (\$50.00)~~ two hundred dollars (\$200.00) per year. Each year during that four-year period, upon request and payment of the fee, the person's name may remain on an inactive list for one additional year.

(f) Any person having a temporary license issued pursuant to G.S. 90-278(3) shall pay a fee in an amount set by the Board not to exceed ~~two hundred dollars (\$200.00)~~ five hundred dollars (\$500.00). If the Board renews the temporary license, no further fee shall be required.

(g) The Board may set fees not to exceed ~~two hundred and fifty dollars (\$250.00)~~ one thousand dollars (\$1,000) for conducting and administering initial training and continuing education courses, and may set a fee not to exceed one hundred dollars (\$100.00) per hour for certifying a course submitted for review by another individual or agency wishing to offer such courses or may set an annual fee not to exceed ~~two thousand dollars (\$2,000)~~ four thousand dollars (\$4,000) for certifying a course provider in lieu of certifying each course offered by the provider."

SECTION 3. G.S. 90-283 reads as rewritten:

"§ 90-283. Organization of Board; compensation; employees and services.

The Board shall elect from its membership a chairman, vice-chairman and secretary, and shall adopt rules and regulations to govern its proceedings. Board members shall be entitled to receive only such compensation and reimbursement as is prescribed by Chapter 93B of the General Statutes for State boards generally. At any meeting a majority of the voting members shall constitute a quorum. The Board ~~may employ any necessary personnel to assist it in the~~

performance of its duties and may contract for such services as may be shall have the power to employ or retain professional personnel, including legal counsel subject to G.S. 114-2.3, and clerical or other special personnel deemed necessary to carry out the provisions of this Article."

SECTION 4. G.S. 90-285(3) reads as rewritten:

"§ 90-285. Functions and duties of the Board.

The Board shall meet at least once annually in Raleigh or any other location designated by the chairman and shall have the following functions and duties:

- (3) Issue licenses to qualified ~~individuals~~ individuals consistent with G.S. 90-278 and G.S. 90-287 and any rules adopted by the Board implementing those provisions.

SECTION 5. G.S. 90-285.1 reads as rewritten:

"§ 90-285.1. Suspension, revocation or refusal to issue a license.

The Board may suspend, revoke, or refuse to issue a license or may reprimand or otherwise discipline a licensee after due notice and an opportunity to be heard at a formal hearing, upon substantial evidence that a licensee:

- (1) Has violated the provisions of this Article or the rules adopted by the Board;
- (2) Has violated the provisions of Part 2 of Article 6 of Chapter 131E of the General Statutes and rules promulgated thereunder;
- (3) Has been convicted of, or has tendered and has had accepted a plea of no contest to, a criminal offense showing professional unfitness;
- (4) Has practiced fraud, deceit, or misrepresentation in securing or procuring a nursing home administrator license;
- (5) Is incompetent to engage in the practice of nursing home administration or to act as a nursing home administrator;
- (6) Has practiced fraud, deceit, or misrepresentation in his capacity as a nursing home administrator;
- (7) Has committed acts of misconduct in the operation of a nursing home under his jurisdiction;
- (8) ~~Is a habitual drunkard;~~
- (9) Is addicted or dependent upon the use of any controlled substance, including, but not limited to, morphine, opium, cocaine, alcohol, or other drugs recognized as resulting in abnormal behavior;
- (10) Has practiced without being registered biennially;
- (11) Has transferred or surrendered possession of, either temporarily or permanently, his license or certificate to any other person;
- (12) Has paid, given, has caused to be paid or given or offered to pay or to give to any person a commission or other valuable consideration for the solicitation or procurement, either directly or indirectly, of nursing home patronage;
- (13) Has been guilty of fraudulent, misleading, or deceptive advertising;
- (14) Has falsely impersonated another licensee;
- (15) Has failed to exercise regard for the safety, health or life of the patient;
- (16) Has permitted unauthorized disclosure of information relating to a patient or his records; or
- (17) Has discriminated among patients, employees, or staff on account of race, sex, gender, religion, color, ~~or national origin~~ national origin, mental or physical disability, or any other class protected by State or federal law."

SECTION 6. G.S. 90-287 reads as rewritten:

"§ 90-287. Reciprocity with other states.

1 The Board may issue a nursing home administrator's ~~license, without examination, license~~
2 to any person who holds a current license as a nursing home administrator from another
3 jurisdiction, provided that the Board finds that the standards for licensure in such other
4 jurisdiction are at least the substantial equivalent of those prevailing in this ~~State, State~~ and that
5 the applicant has passed the national and the State examinations administered by the Board and
6 is otherwise qualified."

7 SECTION 7. G.S. 90-288.01 reads as rewritten:

8 "§ 90-288.01. Criminal history record checks of applicants for licensure.

9 (a) The following definitions apply in this section:

10 (1) Applicant. — A person applying for initial licensure pursuant to either
11 G.S. 90-278 or G.S. 90-287 or applying for renewal of licensure pursuant to
12 G.S. 90-286.

13 (2) Criminal history. — A history of conviction of a state or federal crime,
14 whether a misdemeanor or felony, that bears on an applicant's fitness for
15 licensure as a nursing home administrator. The crimes include the criminal
16 offenses set forth in any of the following Articles of Chapter 14 of the
17 General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes;
18 Article 5A, Endangering ~~Executive and Legislative~~ Executive, Legislative,
19 and Court Officers; Article 6, Homicide; Article 7A, Rape and Other Sex
20 Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article
21 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device
22 or Material; Article 14, Burglary and Other Housebreakings; Article 15,
23 Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article
24 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A,
25 Obtaining Property or Services by False or Fraudulent Use of Credit Device
26 or Other Means; Article 19B, Financial Transaction Card Crime Act; Article
27 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public
28 Morality and Decency; Article 26A, Adult Establishments; Article 27,
29 Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct
30 in Public Office; Article 35, Offenses Against the Public Peace; Article 36A,
31 Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors;
32 Article 40, Protection of the Family; Article 59, Public Intoxication; and
33 Article 60, Computer-Related Crime. The crimes also include possession or
34 sale of drugs in violation of the North Carolina Controlled Substances Act,
35 Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses,
36 including sale to underage persons in violation of G.S. 18B-302 or driving
37 while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

38 (b) Criminal History Record Check. — The Board shall require a criminal history
39 record check of all ~~applicants~~ applicants for initial licensure and temporary licensure. The
40 Board, in its discretion, may require a criminal history record check of an applicant for license
41 renewal. Refusal to consent to a criminal history record check may constitute grounds for the
42 Board to deny licensure to an applicant. The Board shall provide to the North Carolina
43 Department of Justice the fingerprints of the applicant to be checked, a form signed by the
44 applicant consenting to the criminal history record check and the use of fingerprints and other
45 identifying information required by the State or National Repositories, and any additional
46 information required by the Department of Justice. The Board shall keep all information
47 obtained pursuant to this section confidential. The Board shall collect any fees required by the
48 Department of Justice and shall remit the fees to the Department of Justice for expenses
49 associated with conducting the criminal history record check.

50 (c) Convictions. — If the applicant's criminal history record check reveals one or more
51 convictions listed under subdivision (2) of subsection (a) of this section, the conviction shall

not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

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

(d) Denial of Licensure. — ~~If Except as otherwise provided by law, if the Board refuses to issue or renew a license based on information obtained in a criminal history record check, the Board must disclose to the applicant the information contained in the criminal history record check that is relevant to the Board's actions. The Board shall not provide a copy of the criminal history record check to the applicant. An applicant has the right to appear before the Board to appeal the Board's decision. An appearance before the Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.~~

(e) Limited Immunity. — The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for its actions based on information provided in an applicant's criminal history record check."

SECTION 8. Article 20 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"§ 90-288.02. Confidentiality of investigative records.

Records, papers, and other documents containing information collected and compiled by or on behalf of the Board as a result of an investigation, inquiry, or interview conducted in connection with certification, licensure, or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes. Any notice or statement of charges, notice of hearing, or decision rendered in connection with a hearing shall be a public record. Information that identifies a resident who has not consented to the public disclosure of services rendered to him or her by a person certified or licensed under this Chapter shall be deleted from the public record. All other records, papers, and documents containing information collected and compiled by or on behalf of the Board shall be public records, but any information that identifies a resident who has not consented to the public disclosure of services rendered to him or her shall be deleted."

SECTION 9. Any person who has met the qualifications for licensure and been issued a license as a nursing home administrator by the State Board of Examiners for Nursing Home Administrators on or before the effective date of Section 1 of this act shall be deemed to have complied with the requirements of G.S. 90-278(1) as enacted by Section 1 of this act.

SECTION 10. Section 1 of this act becomes effective January 1, 2015. The remainder of this act is effective when it becomes law.



SENATE BILL 488: Amend Nursing Home Administrator Act/Fees

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	Date:	April 30, 2013
Introduced by:	Sen. Tucker	Prepared by:	Barbara Riley
Analysis of:	PCS to First Edition S488-CSRF-16		Committee Counsel

SUMMARY: *Senate Bill 488 increases the educational requirements for licensure as a Nursing Home Administrator, increases various licensure fees, and makes other miscellaneous changes to the Nursing Home Administrator Act. The proposed committee substitute adds a grandfather clause for persons licensed on or before the effective date of Section 1 of the bill, January 1, 2015.*

BILL ANALYSIS: Section 1 of the bill increases the education and experience requirements for licensure as a nursing home administrator. The current standard is the equivalent of two years of college level study or a combination of education and experience acceptable to the Board. As amended, the law will now require a person seeking licensure as nursing home administrator to obtain a bachelor's degree, or an associate's degree in nursing plus 5 years experience as a director of nursing for 5 of the previous 6 years.

In addition to the new educational requirements, an applicant must also pass the national and State examinations designed to test for competency in services provided by nursing homes, laws governing nursing homes, protection of patients' interests, and nursing home administration.

Section 2 of the bill increases licensure fees.

- Fees for applicants for examination or for an administrator in training program go from \$100 to \$500. Persons seeking a reciprocity endorsement under 90-287 shall also pay a \$500 fee.
- Fees for licensure and licensure renewal (biennial) increase from \$500 to \$1,000.
- Fees for obtaining a duplicate license or a verification of license increase from \$25 to \$100.
- Fees for placement on the inactive list (on which a licensee may be placed for up to 4 years) increase from \$50 to \$200 for each year.
- Fees for a temporary license are increased from \$200 to \$500.
- Fees for conducting and administering initial training and continuing education increase from \$250 to \$1,000. Fees for certifying a course submitted for review by another individual or agency wishing to offer a course increases from \$100 to \$100/hour and fees for certifying a course provider, from \$2,000 to \$4,000.

Section 3 amends the Board's authority to hire any necessary personnel to specifically provide that they may employ or retain professional personnel including legal counsel.

Section 4 amends the Board's duty to issue licenses to provide that the licenses be issued in accordance with the qualifications set out in G.S. 90-278 and G.S.90-287.



Senate PCS 488

Page 2

Section 5 amends the provisions on adverse action against a licensee to (1) delete as grounds that a person is a "habitual drunkard"; (2) amend grounds relating to addiction to include addiction or dependency on any controlled substance including alcohol; and (3) to add as grounds discrimination based on mental or physical disability or any other class protected by State or federal law.

Section 6 amends the reciprocity statute to require a licensee in another State to pass the national and State level examinations administered by the Board.

Section 7 amends the Board's authority to request criminal history record checks to allow checks of all applicants for initial and temporary licensure and to allow a check for an applicant seeking licensure renewal. Section 7 further provides that if the Board refuses to issue or renew a license based on the criminal history record check, the Board shall not provide a copy of the record to the applicant.

Section 8 makes records, papers, and other documents collected during an investigation, inquiry or interview in connection with certification, licensure, or a disciplinary matter to be confidential and not a public record pursuant to Chapter 132 of the General Statutes. Board decisions, hearing notices, statements of charges, and material admitted into evidence are public records. Information that identifies a resident who has not consented to public disclosure of services rendered to him or her shall be deleted from the public record.

Section 9 of the bill grandfather's in those persons who became licensed on or before the effective date of the new education and experience requirements.

EFFECTIVE DATE: Section 1 of the act becomes effective January 1, 2015. The remainder of the act is effective when it becomes law.



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 488

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

S488-ARF-3 [v.1]

Page 1 of 1

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

Date _____, 2013

Senator _____

1 moves to amend the bill on page 2, line 4, rewriting that line to read:

2
3 "e. ~~He has~~ Has passed ~~examinations administered by the Board and designed~~;

4
5 And further amends the bill on page 2, lines 23 and 24 by adding after the word "his", the
6 phrase "or her";

7
8 And further amends the bill on page 2, line 30, by rewriting that line to read:
9 "holding himself or herself out to be a nursing home administrator may have his or her name
10 placed on an";

11
12 And further amends the bill on page 3, lines 27, 37 and 45, by adding after the word "his" the
13 phrase "or her".
14
15
16

SIGNED _____

Amendment Sponsor

SIGNED _____

Committee Chair if Senate Committee Amendment

ADOPTED _____

FAILED _____

TABLED _____



★ S 4 8 8 - A R F - 3 - V - 1 ★

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 553

Short Title: LME/MCO Enrollee Grievances & Appeals.

(Public)

Sponsors: Senator Hise (Primary Sponsor).

Referred to: Health Care.

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR MEDICAID
ENROLLEES OF LOCAL MANAGEMENT ENTITIES THAT HAVE BEEN
APPROVED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
OPERATE AS A MANAGED CARE ORGANIZATION UNDER THE 1915(B)/(C)
MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a Chapter to read:

"Chapter 108D.

"Enrollee Grievances and Appeals of LME/MCO Managed Care Actions.

"Article 1.

"General Provisions.

"§ 108D-1. Definitions.

The following definitions apply in this Chapter, unless the context clearly requires otherwise:

- (1) Applicant. – A provider of MH/IDD/SA who is seeking to participate in the closed network of one or more LME/MCOs.
- (2) Closed network. – The network of providers who have contracted with an LME/MCO to furnish MH/IDD/SA services to enrollees.
- (3) Contested case hearing. – The hearing or hearings conducted at OAH pursuant to G.S. 108D-8 to resolve a dispute between an enrollee and an LME/MCO about a managed care action.
- (4) Department. – The North Carolina Department of Health and Human Services.
- (5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
- (7) Enrollee. – A Medicaid beneficiary who is currently enrolled in an MCO or PIHP operated by an LME/MCO.
- (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
- (9) Local Management Entity/Managed Care Organization or LME/MCO. – An LME that has been approved by the Department to operate an MCO or PIHP in accordance with 42 C.F.R. Part 438.
- (10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).
- (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
- (12) MH/IDD/SA. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect



* S 5 5 3 - V - 1 *

between the Department and an LME to operate an MCO or PIHP under the 1915(b)(c) Medicaid Waivers approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of MH/IDD/SA services who has entered into a contract for participation in the closed network of one or more LME/MCOs. The term also includes a provider of emergency services.

(14) Notice of managed care action. – The notice required by 42 C.F.R. § 438.404.

(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).

(16) OAH. – The North Carolina Office of Administrative Hearings.

(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.

(18) Provider. – As defined in G.S. 108C-2(10).

(19) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

§ 108D-2. Scope; applicability of this Chapter.

This Chapter applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider of an LME/MCO.

§ 108D-3. Conflicts; severability.

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Part 438, federal law prevails to the extent of the conflict.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for behavioral health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

§ 108D-4. LME/MCO grievance and appeal procedures, generally.

(a) Each LME/MCO shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees, and network providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.

(b) Enrollees, or network providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. However, unless the enrollee or network provider requests an expedited appeal, the oral filing must be followed by a written, signed grievance or appeal.

(c) An LME/MCO shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an LME/MCO level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or network providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) An LME/MCO shall not take punitive action against a network provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

- (2) Requesting an LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level appeal.
- (3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level expedited appeal.
- (4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

"§ 108D-5. LME/MCO grievances.

(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than a managed care action. Upon receipt of a grievance, an LME/MCO shall acknowledge receipt of the grievance in writing by United States mail.

(b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance as expeditiously as the enrollee's health condition requires, but no later than 90 days after receipt of the grievance. The LME/MCO shall provide the enrollee and all other affected parties with written notice of the grievance disposition by United States mail within this 90-day period.

(c) Right to Request LME/MCO Level Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for an LME/MCO level appeal of a grievance disposition pursuant to G.S. 108D-6 as long as the enrollee or network provider has exhausted the grievance procedure described in this section.

(d) Notice of Right to Request LME/MCO Level Appeal. – In the same mailing as the grievance disposition, the LME/MCO shall also notify the enrollee of the right to file a request for an LME/MCO level appeal of the grievance disposition pursuant to G.S. 108D-6.

"§ 108D-6. Standard LME/MCO level appeals.

(a) Notice of Managed Care Action. – An LME/MCO shall provide an enrollee with written notice of a managed care action by United States mail in a manner consistent with 42 C.F.R. Part 438, Subpart F.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a grievance disposition or a notice of managed care action no later than 30 days after the mailing date of the grievance disposition or notice of managed care action. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal in writing by United States mail.

(c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than 45 days after receiving the request for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this 45-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the grievance procedures described in G.S. 108D-5, if applicable, and the appeal procedures described in G.S. 108D-6 or G.S. 108D-7.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-8(e).

"§ 108D-7. Expedited LME/MCO level appeals.

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or

1 regain maximum function, an enrollee, or a network provider authorized in writing to act on
2 behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care
3 action no later than 30 days after the mailing date of the notice of managed care action. For
4 expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee
5 qualifies for an expedited appeal. For expedited appeal requests made by network providers on
6 behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

7 (b) Notice of Denial for Expedited Appeal. – If the LME/MCO denies a request for an
8 expedited LME/MCO level appeal, the LME/MCO shall make reasonable efforts to give the
9 enrollee and all other affected parties oral notice of the denial and follow up with written notice
10 of denial by United States mail by no later than two calendar days after receiving the request
11 for an expedited appeal. In addition, the LME/MCO shall resolve the appeal within the time
12 limits established for standard LME/MCO level appeals in G.S. 108D-6.

13 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
14 during the pendency of an expedited LME/MCO level appeal to the extent required under 42
15 C.F.R. § 438.420.

16 (d) Notice of Resolution. – If the LME/MCO grants a request for an expedited
17 LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the
18 enrollee's health condition requires and no later than three working days after receiving the
19 request for an expedited appeal. The LME/MCO shall provide the enrollee and all other
20 affected parties with a written notice of resolution by United States mail within this three-day
21 period.

22 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
23 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
24 hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the
25 grievance procedures described in G.S. 108D-5, if applicable, and the appeal procedures
26 described in G.S. 108D-6 or G.S. 108D-7.

27 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
28 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
29 contested case hearing that meets the requirements of G.S. 108D-8(e).

30 **"§ 108D-8. Contested case hearings on disputed managed care actions.**

31 (a) Jurisdiction of OAH. – The Office of Administrative Hearings does not have
32 jurisdiction over a dispute concerning a grievance or managed care action, except as expressly
33 set forth in this Chapter.

34 (b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or
35 rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of
36 resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not
37 apply to enrollees contesting a grievance or managed care action.

38 (c) Request for Contested Case Hearing. – A request for an administrative hearing to
39 appeal a notice of resolution issued by an LME/MCO is a contested case subject to the
40 provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or a network
41 provider authorized in writing to act on behalf of an enrollee, has the right to file a request for
42 appeal to contest a notice of resolution as long as the enrollee or network provider has
43 exhausted the grievance procedures described in G.S. 108D-5, if applicable, and the appeal
44 procedures described in G.S. 108D-6 or G.S. 108D-7.

45 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act
46 on behalf of an enrollee, may appeal a notice of resolution by filing an appeal request form that
47 meets the requirements of subsection (e) of this section at OAH and sending a copy of the filing
48 to the affected LME/MCO by no later than 30 days after the mailing date of the notice of
49 resolution. A request for appeal is deemed filed when a completed and signed appeal request
50 form has been both submitted into the care and custody of the chief hearings clerk of OAH and
51 accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form,

1 information contained in the notice of resolution is no longer confidential, and the LME/MCO
2 shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may
3 dispose of these records after one year.

4 (e) Appeal Request Form. – In the same mailing as the notice of resolution, the
5 LME/MCO shall also provide the enrollee with an appeal request form for a contested case
6 hearing which shall be no more than one side of one page. The form shall include at least all of
7 the following:

8 (1) A statement that in order to request an appeal, the enrollee must file the form
9 by mail or fax at the address or fax number listed on the form by no later
10 than 30 days after the mailing date of the notice of resolution.

11 (2) The enrollee's name, address, telephone number, and Medicaid identification
12 number.

13 (3) A preprinted statement that indicates that the enrollee would like to appeal a
14 grievance disposition or a specific managed care action identified in the
15 notice of resolution.

16 (4) A statement informing the enrollee of the right to be represented at the
17 contested case hearing by a lawyer, a relative, a friend, or other
18 spokesperson.

19 (5) A space for the enrollee's signature and date.

20 (f) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
21 during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420.
22 Notwithstanding any other provision of State law, the administrative law judge does not have
23 the power to order and shall not order an LME/MCO to continue benefits in excess of what is
24 required by 42 C.F.R. § 438.420.

25 (g) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
26 150B of the General Statutes, the chief administrative law judge of OAH may limit and
27 simplify the administrative hearing procedures that apply to contested case hearings conducted
28 pursuant to this section in order to complete these cases as expeditiously as possible. Any
29 simplified hearing procedures approved by the chief administrative law judge pursuant to this
30 subsection must comply with all of the following requirements:

31 (1) OAH shall schedule and hear cases by no later than 55 days after receipt of a
32 request for a contested case hearing.

33 (2) OAH shall conduct all contested case hearings telephonically or by video
34 technology with all parties, unless the enrollee requests that the hearing be
35 conducted in person before the administrative law judge. An in-person
36 hearing shall be conducted in Wake County unless the enrollee's
37 impairments limit travel. For enrollees with impairments that limit travel, an
38 in-person hearing shall be conducted in the enrollee's county of residence.
39 OAH shall provide written notice to the enrollee of the use of telephonic
40 hearings, hearings by video conference, and in-person hearings before the
41 administrative law judge, as well as written instructions on how to request a
42 hearing in the enrollee's county of residence.

43 (3) The administrative law judge assigned to hear the case shall consider and
44 rule on all prehearing motions prior to the scheduled date for a hearing on
45 the merits.

46 (4) Neither an enrollee nor an LME/MCO is required to be represented by an
47 attorney at a contested case hearing. For cases in which the enrollee is not
48 represented by an attorney, the administrative law judge assigned to hear the
49 case shall make reasonable efforts to assure a fair hearing and to maintain a
50 complete record of the hearing.

(5) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by United States mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(6) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the LME/MCO in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the Department's expense and made part of the record, including all of the following:

1. A hearing involving medical issues such as a diagnosis, an examining physician's report, or a decision by a medical review team.

2. A hearing in which the administrative law judge considers it necessary to have a medical assessment other than the medical assessment performed by an individual involved in any previous level of review or decision making.

(h) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing pursuant to this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(i) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the LME/MCO's managed care action and regardless of whether the LME/MCO had an opportunity to consider the evidence in resolving the LME/MCO level appeal. Upon the receipt of new evidence and at the request of the LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken against the enrollee, it shall immediately inform the administrative law judge of its decision.

(j) Issue for Hearing. – For each managed care action, the administrative law judge shall determine whether the LME/MCO substantially prejudiced the rights of the enrollee and whether the LME/MCO, based upon evidence at the hearing:

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

(3) Failed to use proper procedure.

(4) Acted arbitrarily or capriciously.

(5) Failed to act as required by law or rule.

(k) To the extent that anything in this Part, Chapter 150B of the General Statutes, or any rules or policies adopted pursuant to these Chapters is inconsistent with the Social Security Act

1 or 42 C.F.R. Subpart F, Part 438, federal law prevails and applies to the extent of the conflict.
2 All rules, rights, and procedures for contested case hearings concerning managed care actions
3 shall be construed so as to be consistent with federal law and shall provide the enrollee with no
4 lesser and no greater rights than those provided under federal law.

5 **"§ 108D-9. Notice of final decision and right to seek judicial review.**

6 The administrative law judge assigned to conduct a contested case hearing pursuant to
7 G.S. 108D-8 shall hear and decide the case without unnecessary delay. The judge shall prepare
8 a written decision that includes findings of fact and conclusions of law and send it to the parties
9 in accordance with G.S. 150B-37. The written decision shall notify the parties of the final
10 decision and of the right of the enrollee and the LME/MCO to seek judicial review of the
11 decision pursuant to Article 4 of Chapter 150B of the General Statutes."

12 **SECTION 2.** G.S. 122C-3 is amended by adding a new subdivision to read:

13 **"(20c) "Local management entity-managed care organization" or "LME/MCO"**
14 **means an LME that has been approved by the Department to operate a**
15 **managed care organization or prepaid inpatient health plan in accordance**
16 **with 42 C.F.R. Part 438."**

17 **SECTION 3.** G.S. 122C-151.3 reads as rewritten:

18 **"§ 122C-151.3. Dispute with area authorities or county programs.**

19 **(a)** An area authority or county program shall establish written procedures for resolving
20 disputes over decisions of an area authority or county program that may be appealed to the
21 State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and
22 shall provide an opportunity for those who dispute the decision to present their position.

23 **(b)** This section does not apply to a grievance or appeal of a managed care action by a
24 Medicaid beneficiary currently enrolled in a managed care organization or a prepaid inpatient
25 health plan operated by an LME/MCO who is subject to Chapter 108D of the General Statutes."

26 **SECTION 4.** G.S. 122C-151.4(g) reads as rewritten:

27 **"(g)** ~~This section does not apply to providers of community support services who appeal~~
28 ~~directly to the Department of Health and Human Services under the Department's community~~
29 ~~support provider appeal process.~~ **a grievance or appeal of a managed care action by a Medicaid**
30 **beneficiary currently enrolled in a managed care organization or a prepaid inpatient health plan**
31 **operated by an LME/MCO that is subject to Chapter 108D of the General Statutes."**

32 **SECTION 5.** G.S. 84-2.1 reads as rewritten:

33 **"§ 84-2.1. "Practice law" defined.**

34 The phrase "practice law" as used in this Chapter is defined to be performing any legal
35 service for any other person, firm or corporation, with or without compensation, specifically
36 including the preparation or aiding in the preparation of deeds, mortgages, wills, trust
37 instruments, inventories, accounts or reports of guardians, trustees, administrators or executors,
38 or preparing or aiding in the preparation of any petitions or orders in any probate or court
39 proceeding; abstracting or passing upon titles, the preparation and filing of petitions for use in
40 any court, including administrative tribunals and other judicial or quasi-judicial bodies, or
41 assisting by advice, counsel, or otherwise in any legal work; and to advise or give opinion upon
42 the legal rights of any person, firm or corporation: Provided, that the above reference to
43 particular acts which are specifically included within the definition of the phrase "practice law"
44 shall not be construed to limit the foregoing general definition of the term, but shall be
45 construed to include the foregoing particular acts, as well as all other acts within the general
46 definition. The phrase "practice law" does not encompass ~~the any of the following:~~

47 **(1)** The writing of memoranda of understanding or other mediation summaries
48 by mediators at community mediation centers authorized by G.S. 7A-38.5 or
49 by mediators of personnel matters for The University of North Carolina or a
50 constituent institution.

- 1 (2) The representation of an LME/MCO by an employee or a contractor of the
- 2 LME/MCO in a contested case hearing under G.S. 108D-8."
- 3 **SECTION 6.** This act becomes effective July 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 553
PROPOSED COMMITTEE SUBSTITUTE S553-PCS35336-SH-13

Short Title: LME/MCO Enrollee Grievances & Appeals.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR LOCAL
MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION (LME/MCO)
MEDICAID ENROLLEES.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"Chapter 108D.

"LME/MCO Enrollee Grievances and Appeals.

"Article 1.

"General Provisions.

"§ 108D-1. Definitions.

The following definitions apply in this Chapter, unless the context clearly requires otherwise:

- (1) Applicant. – A provider of MH/IDD/SA services who is seeking to participate in the closed network of one or more LME/MCOs.
- (2) Closed network. – A network of providers that have contracted with an LME/MCO to furnish MH/IDD/SA services to enrollees.
- (3) Contested case hearing. – The hearing or hearings conducted at OAH pursuant to G.S. 108D-8 to resolve a dispute between an enrollee and an LME/MCO about a managed care action.
- (4) Department. – The North Carolina Department of Health and Human Services.
- (5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
- (7) Enrollee. – A Medicaid beneficiary who is currently enrolled with an LME/MCO.
- (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
- (9) Local Management Entity/Managed Care Organization or LME/MCO. – An LME that has contracted with the Department to operate an MCO or PIHP in accordance with 42 C.F.R. § 438.
- (10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).
- (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
- (12) MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department and an LME to operate an MCO or PIHP under the



* S 5 5 3 - P C S 3 5 3 3 6 - S H - 1 3 *

1915(b)/(c) Medicaid Waivers approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of MH/IDD/SA services who has entered into a contract for participation in the closed network of one or more LME/MCOs. The term also includes a provider of emergency services.

(14) Notice of managed care action. – The notice required by 42 C.F.R. § 438.404.

(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).

(16) OAH. – The North Carolina Office of Administrative Hearings.

(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.

(18) Provider. – As defined in G.S. 108C-2(10).

(19) Provider of emergency services. – A provider who is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

§ 108D-2. Scope; applicability of this Chapter.

This Chapter applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider of an LME/MCO.

§ 108D-3. Conflicts; severability.

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Part 438, federal law prevails to the extent of the conflict.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for behavioral health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

§ 108D-4. LME/MCO enrollee grievance and appeal procedures, generally.

(a) Each LME/MCO shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees, and network providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.

(b) Enrollees, or network providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. An oral filing must be followed by a written, signed grievance or appeal unless the enrollee or network provider requests an expedited appeal.

(c) An LME/MCO shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an LME/MCO level appeal, or a request for a contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or network providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) An LME/MCO shall not take punitive action against a network provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

- (2) Requesting an LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level appeal.
- (3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level expedited appeal.
- (4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

"§ 108D-5. LME/MCO enrollee grievances.

(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than a managed care action. Upon receipt of a grievance, an LME/MCO shall acknowledge receipt of the grievance in writing by United States mail.

(b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance as expeditiously as the enrollee's health condition requires, but no later than 90 days after receipt of the grievance. The LME/MCO shall provide the enrollee and all other affected parties with written notice of the grievance disposition by United States mail within this 90-day period.

(c) No Appeal of a Grievance Disposition. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, receiving a grievance disposition has no right to the administrative appeal procedures described in G.S. 108D-6, 108D-7, and 108D-8.

"§ 108D-6. Standard LME/MCO enrollee level appeals.

(a) Notice of Managed Care Action. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of a managed care action, an LME/MCO shall provide an enrollee with written notice of a managed care action and of the enrollee's right to appeal the managed care action. The LME/MCO shall not be required to notify an enrollee's parent, guardian, or legal representative unless the enrollee's parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

- (1) An identification of the enrollee whose services are being affected by the managed care action, including the enrollee's full name and Medicaid identification number.
- (2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.
- (3) The specific regulation, statute, or medical policy that supports or requires the managed care action.
- (4) The effective date of the managed care action.
- (5) An explanation of the recipient's right to appeal the LME/MCO's managed care action in an evidentiary hearing before an administrative law judge.
- (6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.
- (7) A statement regarding the enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
- (8) The name and telephone number of a contact person at the LME/MCO to respond in a timely fashion to the enrollee's questions.
- (9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.
- (10) The appeal request form that the enrollee may use to request a hearing.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a

1 notice of managed care action no later than 30 days after the mailing date of the notice of
2 managed care action. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO
3 shall acknowledge receipt of the request for appeal in writing by United States mail.

4 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
5 during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R.
6 § 438.420.

7 (d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as
8 the enrollee's health condition requires, but no later than 45 days after receiving the request for
9 appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written
10 notice of resolution by United States mail within this 45-day period.

11 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
12 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
13 hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the
14 appeal procedures described in G.S. 108D-6 or G.S. 108D-7, if applicable.

15 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
16 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
17 contested case hearing that meets the requirements of G.S. 108D-8(e).

18 **"§ 108D-7. Expedited LME/MCO enrollee level appeals.**

19 (a) Request for Expedited Appeal. – When the time limits for completing a standard
20 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or
21 regain maximum function, an enrollee, or a network provider authorized in writing to act on
22 behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care
23 action no later than 30 days after the mailing date of the notice of managed care action. For
24 expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee
25 qualifies for an expedited appeal. For expedited appeal requests made by network providers on
26 behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

27 (b) Notice of Denial for Expedited Appeal. – If the LME/MCO denies a request for an
28 expedited LME/MCO level appeal, the LME/MCO shall make reasonable efforts to give the
29 enrollee and all other affected parties oral notice of the denial and follow up with written notice
30 of denial by United States mail by no later than two calendar days after receiving the request
31 for an expedited appeal. In addition, the LME/MCO shall resolve the appeal within the time
32 limits established for standard LME/MCO level appeals in G.S. 108D-6.

33 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
34 during the pendency of an expedited LME/MCO level appeal to the extent required under 42
35 C.F.R. § 438.420.

36 (d) Notice of Resolution. – If the LME/MCO grants a request for an expedited
37 LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the
38 enrollee's health condition requires and no later than three working days after receiving the
39 request for an expedited appeal. The LME/MCO shall provide the enrollee and all other
40 affected parties with a written notice of resolution by United States mail within this three-day
41 period.

42 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
43 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
44 hearing pursuant to G.S. 108D-8 as long as the enrollee, or network provider, has exhausted the
45 appeal procedures described in G.S. 108D-6 or G.S. 108D-7.

46 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
47 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
48 contested case hearing that meets the requirements of G.S. 108D-8(e).

49 **"§ 108D-8. Contested case hearings on disputed managed care actions.**

50 (a) Jurisdiction of OAH. – The Office of Administrative Hearings does not have
51 jurisdiction over a dispute concerning a grievance. The Office of Administrative Hearings does

not have jurisdiction over a dispute involving a managed care action, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting a managed care action.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution issued by an LME/MCO is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for appeal to contest a notice of resolution as long as the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-6 or G.S. 108D-7, if applicable.

(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may appeal a notice of resolution by filing an appeal request form that meets the requirements of subsection (f) of this section at OAH and sending a copy of the filing to the affected LME/MCO by no later than 30 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The LME/MCO shall be the respondent for purposes of this appeal. Either the LME/MCO or enrollee may move for the permissive joinder of the Department pursuant to Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party pursuant to Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

- (1) A statement that in order to request an appeal, the enrollee must file the form by mail or fax at the address or fax number listed on the form by no later than 30 days after the mailing date of the notice of resolution.
- (2) The enrollee's name, address, telephone number, and Medicaid identification number.
- (3) A preprinted statement that indicates that the enrollee would like to appeal a specific managed care action identified in the notice of resolution.
- (4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.
- (5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order an LME/MCO to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures conducted pursuant to this section in order to complete the case as quickly as possible.

- 1 (1) To the extent possible, OAH shall schedule and hear contested Medicaid
2 cases within 55 days of submission of a request for appeal.
- 3 (2) OAH shall conduct all contested case hearings telephonically or by video
4 technology with all parties, unless the enrollee requests that the hearing be
5 conducted in person before the administrative law judge. An in-person
6 hearing shall be conducted in the county that contains the North Carolina
7 headquarters of the LME/MCO; however, for good cause shown, the
8 in-person hearing may be conducted in the county of residence of the
9 enrollee or a nearby county. Good cause shall include, but is not limited to,
10 the enrollee's impairments limiting travel or the unavailability of the
11 enrollee's treating professional witnesses. OAH shall provide written notice
12 to the enrollee of the use of telephonic hearings, hearings by video
13 conference, and in-person hearings before the administrative law judge, and
14 how to request a hearing in the enrollee's county of residence.
- 15 (3) The simplified procedure may include requiring that all prehearing motions
16 be considered and ruled on by the administrative law judge in the course of
17 the hearing of the case on the merits. An administrative law judge assigned
18 to a contested Medicaid case shall make reasonable efforts in a case
19 involving an enrollee who is not represented by an attorney to assure a fair
20 hearing and to maintain a complete record of the hearing.
- 21 (4) The administrative law judge may allow brief extensions of the time limits
22 contained in this section for good cause and to ensure that the record is
23 complete. Good cause includes delays resulting from untimely receipt of
24 documentation needed to render a decision and other unavoidable and
25 unforeseen circumstances. Continuances shall only be granted in accordance
26 with rules adopted by OAH and shall not be granted on the day of the
27 hearing, except for good cause shown. If a petitioner fails to make an
28 appearance at a hearing that has been properly noticed via certified mail by
29 OAH, OAH shall immediately dismiss the contested case, unless the
30 recipient moves to show good cause within three business days of the date of
31 dismissal.
- 32 (5) The notice of hearing provided by OAH to the enrollee shall include the
33 following information:
- 34 a. The enrollee's right to examine at a reasonable time before the
35 hearing and during the hearing the contents of the enrollee's case file
36 and documents to be used by the LME/MCO in the hearing before
37 the administrative law judge.
- 38 b. The recipient's right to an interpreter during the appeals process.
- 39 c. Circumstances in which a medical assessment may be obtained at
40 agency expense and be made part of the record. Qualifying
41 circumstances include those in which (i) a hearing involves medical
42 issues, such as a diagnosis, an examining physician's report, or a
43 medical review team's decision; and (ii) the administrative law judge
44 considers it necessary to have a medical assessment other than that
45 performed by the individual involved in making the original decision.
- 46 (i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-8(f)
47 or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation
48 Network of North Carolina, which shall contact the recipient within five days to offer
49 mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be
50 completed within 25 days of submission of the request for appeal. Upon completion of the
51 mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the

1 resolution by facsimile or electronic messaging. If the parties have resolved matters in the
2 mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case
3 involving a dispute of a managed care action until it has received notice from the mediator
4 assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer
5 of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. Nothing in
6 this subsection shall restrict the right to a contested case hearing.

7 (j) Burden of Proof. – The enrollee has the burden of proof to show entitlement to a
8 requested benefit or the propriety of requested action when the LME/MCO has denied the
9 benefit or refused to take the particular action. The agency has the burden of proof when the
10 appeal is from a managed care action to impose a penalty or to reduce, terminate, or suspend a
11 previously granted benefit. The party with the burden of proof on any issue has the burden of
12 going forward, and the administrative law judge shall not make any ruling on the
13 preponderance of evidence until the close of all evidence.

14 (k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of
15 whether it was obtained before or after the LME/MCO's managed care action and regardless of
16 whether the LME/MCO had an opportunity to consider the evidence in resolving the
17 LME/MCO level appeal. Upon the receipt of new evidence and at the request of the
18 LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days
19 and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon
20 reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken
21 against the enrollee, it shall immediately inform the administrative law judge of its decision.

22 (l) Issue for Hearing. – For each managed care action, the administrative law judge
23 shall determine whether the LME/MCO substantially prejudiced the rights of the enrollee and
24 whether the LME/MCO, based upon evidence at the hearing:

- 25 (1) Exceeded its authority or jurisdiction.
- 26 (2) Acted erroneously.
- 27 (3) Failed to use proper procedure.
- 28 (4) Acted arbitrarily or capriciously.
- 29 (5) Failed to act as required by law or rule.

30 (m) To the extent that anything in this Part, Chapter 150B of the General Statutes, or any
31 rules or policies adopted pursuant to these Chapters is inconsistent with the Social Security Act
32 or 42 C.F.R. Subpart F, Part 438, federal law prevails and applies to the extent of the conflict.
33 All rules, rights, and procedures for contested case hearings concerning managed care actions
34 shall be construed so as to be consistent with federal law and shall provide the enrollee with no
35 lesser and no greater rights than those provided under federal law.

36 **"§ 108D-9. Notice of final decision and right to seek judicial review.**

37 The administrative law judge assigned to conduct a contested case hearing pursuant to
38 G.S. 108D-8 shall hear and decide the case without unnecessary delay. The judge shall prepare
39 a written decision that includes findings of fact and conclusions of law and send it to the parties
40 in accordance with G.S. 150B-37. The written decision shall notify the parties of the final
41 decision and of the right of the enrollee and the LME/MCO to seek judicial review of the
42 decision pursuant to Article 4 of Chapter 150B of the General Statutes."

43 **SECTION 2.** G.S. 122C-3 is amended by adding a new subdivision to read:

44 **"(20c) "Local management entity/managed care organization" or "LME/MCO"**
45 **means an LME that has been approved by the Department to operate the**
46 **1915(b)/(c) Medicaid Waiver."**

47 **SECTION 3.** G.S. 122C-151.3 reads as rewritten:

48 **"§ 122C-151.3. Dispute with area authorities or county programs.**

49 (a) An area authority or county program shall establish written procedures for resolving
50 disputes over decisions of an area authority or county program that may be appealed to the

1 State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and
2 shall provide an opportunity for those who dispute the decision to present their position.

3 (b) This section does not apply to enrollee grievances or appeals subject to Chapter
4 108D of the General Statutes."

5 SECTION 4. G.S. 122C-151.4(g) reads as rewritten:

6 "(g) This section does not apply to ~~providers of community support services who appeal~~
7 ~~directly to the Department of Health and Human Services under the Department's community~~
8 ~~support provider appeal process.~~ enrollee grievances or appeals subject to Chapter 108D of the
9 General Statutes."

10 SECTION 5. G.S. 150B-23 is amended by adding a new subsection to read:

11 "(a3) A Medicaid enrollee, or network provider authorized in writing to act on behalf of
12 the enrollee, who appeals a notice of resolution issued by an LME/MCO pursuant to Chapter
13 108D may commence a contested case under this Article in the same manner as any other
14 petitioner. The case shall be conducted in the same manner as other contested cases under this
15 Article. For purposes of contested cases commenced under this subsection, an LME/MCO is an
16 agency."

17 SECTION 6. On or before December 1, 2013, the Department of Health and
18 Human Services shall submit to the Centers for Medicare and Medicaid Services, a Medicaid
19 State Plan Amendment necessary to implement this act.

20 SECTION 7. This act becomes effective June 1, 2014, upon approval by the
21 Centers for Medicare and Medicaid Services of the Medicaid State Plan Amendment required
22 in Section 6 of this act. The Department of Health and Human Services shall report to the
23 Revisor of Statutes when approval is obtained and the date of the approval.



SENATE BILL 553: LME/MCO Enrollee Grievances & Appeals

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Judiciary II	Date:	April 30, 2013
Introduced by:	Sen. Hise	Prepared by:	Theresa Matula
Analysis of:	PCS to First Edition S553-CSSH-13		Committee Staff

SUMMARY: *The PCS for Senate Bill 553 establishes a Local Management Entity/Managed Care Organization (LME/MCO) process for enrollee grievances and appeals of managed care actions.*

BACKGROUND: S.L. 2011-264 (HB 916), as amended by Section 13 of S.L. 2012-151, directed the Department of Health and Human Services to proceed with statewide restructuring of the management responsibilities for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through the expansion of the 1915(b)/(c) Medicaid Waiver. "1915(b)/(c) Medicaid Waiver" refers to two sections of the Social Security Act allowing states to apply for a waiver from Medicaid policy. A 1915(b) waiver allows the State to provide services through managed care systems or to otherwise limit the choice of providers and 1915(c) waiver allows the State to provide services in a home and community setting rather than an institutional setting. North Carolina is concurrently implementing these two types of waivers.

Senate Bill 553 contains references to numerous sections in 42 C.F.R., Part 438. Title 42 of the Code of Federal Regulations (C.F.R.) pertains to Public Health; Chapter IV of Subchapter C, pertains to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, Medical Assistance Programs; and Part 438 provides for Managed Care. Part 438 is divided into Subparts A-J. Subpart F outlines a Grievance System.

BILL ANALYSIS: SECTION 1 of the PCS for Senate Bill 553 establishes a new Chapter 108D providing for Local Management Entity/Managed Care Organization (LME/MCO) Enrollee Grievances and Appeals.

Definitions (G.S. 108D-1) provides definitions for the following terms: applicant, closed network, contested case hearing, department, emergency medical condition, emergency services, enrollee, local management entity (LME), local management entity/managed care organization (LME/MCO), managed care action, managed care organization (MCO), MH/IDD/SA, network provider, notice of managed care action, notice of resolution, OAH, Prepaid Inpatient Health Plan (PIHP), provider, provider of emergency services.

Application and Conflicts (G.S. 108D-2 and G.S. 108D-3) specifies that Chapter 108D applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider. The new section contains a severability clause; specifies that with regard to conflicts between federal and State law, federal law prevails; and specifies that with regard to conflict between Chapter 108D and other State law, Chapter 108D prevails.

General Outline of Grievance and Appeal Procedures (G.S. 108D-4) establishes a general outline of the LME/MCO grievance and appeal procedures, including the elements as follows:

O. Walker Reagan
Director



Research Division
(919) 733-2578

Senate PCS 553

Page 2

- Each LME/MCO is required to establish and maintain internal grievance and appeal procedures that (i) comply with applicable federal laws, and (ii) provide enrollees constitutional rights to due process and a fair hearing.
- Enrollees, or providers authorized to act on their behalf, must file requests for grievances and LME/MCO level appeals orally or in writing.
- LME/MCO must not attempt to influence, limit, or interfere with the decision to file a grievance, request an appeal, or request a contested case hearing. However, an LME/MCO is not prevented from offering alternative services, engaging in clinical or educational discussions, or engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.
- LME/MCO must not take punitive action against a network provider for supporting or for requesting the following actions on behalf of an enrollee: grievance, LME/MCO level appeal, expedited LME/MCO level appeal, or a contested case hearing.

Specific Grievance and Appeal Procedures (G.S. 108D- 5, 6, 7, 8, and 9)

LME/MCO Grievances (G.S. 108D-5) – Allows an enrollee, or provider acting on behalf of an enrollee, to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than a managed care action (defined in G.S. 108D-1(10)). The LME/MCO must resolve the grievance and provide the enrollee and other affected parties written notice of the grievance disposition by mail no later than 90 days after receipt. Once a grievance disposition is received, there is no right to further administrative appeal under this bill.

Standard LME/MCO Appeals (G.S. 108D-6) – G.S. 108D-6(a), pertaining to Notice of Managed Care Action, mirrors language in G.S. 108A-70.9A(c) providing notice for Medicaid recipient appeals. In general, the section provides that not later than 30 days after the mailing date of a notice of a managed care action, an enrollee, or provider acting on behalf of an enrollee, may file a request for an LME/MCO level appeal. An LME/MCO must acknowledge receipt of the appeal by mail, continue the enrollee's benefits during the pendency of an appeal as required by federal law (42 C.F.R. Part 438.20), and resolve the appeal and provide written notice by mail not later than 45 days after receiving the appeal request. The mailing with the notice of resolution must include an appeal request form for a contested case hearing.

Expedited LME/MCO Appeals (G.S. 108D-7) – An expedited appeal for a managed care action may be filed when time limits for a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. A request for an expedited appeal must be filed no later than 30 days after the mailing date of the notice of the managed care action.

The LME/MCO will determine if an enrollee qualifies for an expedited appeal. If the LME/MCO denies a request for an expedited appeal it must make reasonable efforts to give oral notice, followed by written notice via mail, within 2 calendar days of the expedited appeal request to the enrollee and other affected parties. When an LME/MCO denies a request for expedited appeal it must resolve the appeal within the time required for standard appeals (in G.S. 108D-6). An LME/MCO must presume an expedited appeal is necessary if the appeal is made on behalf of an enrollee by a network provider.

The LME/MCO must continue the enrollee's benefits during the pendency of an expedited appeal to the extent required by federal law and resolve the expedited appeal and provide the enrollee and affected parties written notice by mail within 3 working days. The mailing with the notice of resolution must include an appeal request form for a contested case hearing.

Contested Case Hearings (G.S. 108D-8) – G. S. 108D-8(f) pertaining to the Appeal Request Form is similar to existing law in G.S. 108A-70.9A(e) for Medicaid appeals. Additionally, the following subsections in G.S. 108D-8 mirror, or are similar to subsections contained in current law (G.S. 108A-

Senate PCS 553

Page 3

70.9B) providing for Medicaid Contested Cases and therefore have not been summarized: (h) Simple Procedures;¹ (i) Mediation, (i) Burden of Proof; (k) New Evidence; and (l) Issue for Hearing. In general the section provides that an enrollee, or network provider authorized in writing to act on behalf of an enrollee, may appeal a notice of resolution by filing an appeal request form at OAH and sending a copy of the filing to the affecting LME/MCO no later than 30 days after the mailing of the notice of resolution. The LME/MCO is the respondent for purposes of the appeal and either the LME/MCO or enrollee may move for the permissive joinder of the Department, pursuant to Rule 20 of the NC Rules of Civil Procedure. The Department may move to intervene as a necessary party pursuant to Rules 19 and 24 of the NC Rule of Civil Procedure. The LME/MCO must continue the enrollee's benefits during the pendency of an appeal as required by federal law (42 C.F.R., Part 438.420).

Notice of final decision/right to seek judicial review (G.S. 108D-9) - Similar to the provisions in G.S. 108A-70.9A(f) for contested Medicaid cases, the administrative law judge must hear and decide the case without unnecessary delay and prepare a written decision including the findings of fact and conclusions of law that must be sent to the parties in accordance with G.S. 150B-37. The written decision will notify the parties of the final decision and the right of the enrollee and the LME/MCO to seek judicial review pursuant to Article 4 of Chapter 150B.

SECTIONS 2, 3 and 4 make the following changes to Chapter 122C pertaining to Mental Health, Developmental Disabilities, and Substance Abuse.

- Section 2 adds a definition for "LME/MCO" to G.S. 122C-3.
- Section 3 amends G.S. 122C-151.3 to specify that the statutory section regarding the dispute with area authorities or county programs does not apply to enrollee grievances or appeal subject to Chapter 108D.
- Section 4 amends G.S. 122C-151.4(g) pertaining to appeals to State MH/DD/SA Appeals Panel to provide that the section does not apply to enrollee grievances or appeals subject to Chapter 108D.

SECTION 5 amends G.S. 150B-23 to add a new subsection providing that a Medicaid enrollee, or network provider acting on behalf of an enrollee, who appeals a notice of resolution issued by an LME/MCO may commence a contested case in the same manner as any other petitioner and the case shall be conducted in the same manner as other contested cases. It further specifies that for purposes of contested cases under the subsection, an LME/MCO is an agency.

SECTION 6 requires the Department to submit the Medicaid State Plan Amendment (SPA) required to implement the bill to the Centers for Medicare and Medicaid Services (CMS) on or before December 1, 2013.

EFFECTIVE DATE: Senate Bill 553 would become effective June 1, 2014, upon approval by CMS of the Medicaid SPA required in Section 6. The Department is required to report to the Revisor of Statutes when approval is obtained and the date of the approval.

CURRENT LAW: G.S. 108A-70.9A and 108A-70.9B govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department to deny, terminate, suspend, or reduce a recipient's request for Medicaid services. Under current law, the Department must send the recipient a written notice 10 days before the adverse determination will take effect. The notice must include certain

¹ G.S. 108D-8(h) (2) allows the in-person hearing to be conducted in the county that contains the NC headquarters of the LME/MCO, G.S. 108A-70.9B(b)(2) pertaining to contested Medicaid cases requires the in-person hearing to be conducted in Wake County.

Senate PCS 553

Page 4

elements as specified. The recipient has 30 days from the mailing of the notice to request a hearing by sending the appeal request form to the Office of Administrative Hearings (OAH).

Once an appeal has been requested, the parties have an opportunity for mediation with the Mediation Network of North Carolina. In general, OAH must schedule and hear the case within 55 days of the date the appeal was requested; OAH must send the recipient a notice of hearing and the administrative law judge (ALJ) may allow brief extensions of time for good cause and to ensure that the record is complete.

In general, hearings are conducted by telephone, but the recipient may request that the hearing be conducted in person in Wake County. The in-person hearing may be conducted in another county if the recipient shows good cause.

During the hearing process, the recipient is allowed to submit new evidence regardless of whether it was obtained before or after the Department's actions. The recipient has the burden of proof unless the adverse determination is an action on a previously granted benefit. The ALJ decides whether the Department substantially prejudiced the rights of the recipient and if the Department exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule. After the hearing, the ALJ sends the final decision to the parties, and either party may seek judicial review in superior court.

Jennifer Hillman, Research Division attorney, provided the Current Law summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 530
PROPOSED COMMITTEE SUBSTITUTE S530-CSTK-24 [v.1]

4/30/2013 3:00:19 PM

Short Title: Prohibit E-Cigarette Sales to Minors.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO PROHIBIT THE DISTRIBUTION OF TOBACCO-DERIVED PRODUCTS
AND VAPOR PRODUCTS TO MINORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-313 reads as rewritten:

"Article 39.

"Protection of Minors.

"§ 14-313. Youth access to tobacco ~~products~~ products, tobacco-derived products, vapor products, and cigarette wrapping papers.

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

(1) Distribute. – To sell, furnish, give, or provide tobacco products, tobacco-derived products, or vapor products, including tobacco ~~products~~ samples, or cigarette wrapping papers to the ultimate consumer.

(2) Proof of age. – A drivers license or other photographic identification that includes the bearer's date of birth that purports to establish that the person is 18 years of age or older.

(3) Sample. – A tobacco ~~product~~ product, tobacco-derived product, or vapor product distributed to members of the general public at no cost for the purpose of promoting the product.

(3a) Tobacco-derived product. – Any noncombustible product derived from tobacco that contains nicotine and is intended for human consumption, whether chewed, absorbed, dissolved, ingested, or by other means. This term does not include a vapor product or any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.

(4) Tobacco product. – Any product that contains tobacco and is intended for human consumption. The term does not include a tobacco-derived product or a vapor product.

(5) Vapor product. – Any noncombustible product containing nicotine that employs a mechanical heating element, battery, or electronic circuit, regardless of shape or size and that can be used to heat a liquid nicotine solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe. The term does not include any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.



* S 5 3 0 - C S T K - 2 4 - V - 1 *

(b) Sale or distribution to persons under the age of 18 years. – If any person shall distribute, or aid, assist, or abet any other person in distributing tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers to any person under the age of 18 years, or if any person shall purchase tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers on behalf of a ~~person, less than~~ person under the age of 18 years, the person shall be guilty of a Class 2 misdemeanor; provided, however, that it shall not be unlawful to distribute tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers to an employee when required in the performance of the employee's duties. Retail distributors of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall prominently display near the point of sale a sign in letters at least five-eighths of an inch high which states the following:

N.C. LAW STRICTLY PROHIBITS

THE PURCHASE OF TOBACCO ~~PRODUCTS-PRODUCTS,~~ TOBACCO-DERIVED PRODUCTS, VAPOR PRODUCTS, AND CIGARETTE WRAPPING PAPERS.

BY PERSONS UNDER THE AGE OF 18.

PROOF OF AGE REQUIRED.

Failure to post the required sign shall be an infraction punishable by a fine of twenty-five dollars (\$25.00) for the first offense and seventy-five dollars (\$75.00) for each succeeding offense.

A person engaged in the sale of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Retail distributors of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall train their sales employees in the requirements of this law. Proof of any of the following shall be a defense to any action brought under this subsection:

- (1) The defendant demanded, was shown, and reasonably relied upon proof of age in the case of a retailer, or any other documentary or written evidence of age in the case of a nonretailer.
- (2) The defendant relied on the electronic system established and operated by the Division of Motor Vehicles pursuant to G.S. 20-37.02.
- (3) The defendant relied on a biometric identification system that demonstrated (i) the purchaser's age to be at least the required age for the purchase and (ii) the purchaser had previously registered with the seller or seller's agent a drivers license, a special identification card issued under G.S. 20-377.7, a military identification card, or a passport showing the purchaser's date of birth and bearing a physical description of the person named on the card.

(b1) ~~Vending machines.~~ Distribution of tobacco products, tobacco-derived products, or vapor products. – Tobacco ~~products-products,~~ tobacco-derived products, vapor products, or components of vapor products shall not be distributed in vending machines; provided, however, vending machines distributing tobacco ~~products-products,~~ tobacco-derived products, vapor products, or components of vapor products are permitted (i) in any establishment which is open

only to persons 18 years of age and older; or (ii) in any establishment if the vending machine is under the continuous control of the owner or licensee of the premises or an employee thereof and can be operated only upon activation by the owner, licensee, or employee prior to each purchase and the vending machine is not accessible to the public when the establishment is closed. The owner, licensee, or employee shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Proof that the defendant demanded, was shown, and reasonably relied upon proof of age shall be a defense to any action brought under this subsection. Vending machines distributing tobacco products in establishments not meeting the above conditions shall be removed prior to December 1, 1997. Vending machines distributing tobacco-derived products, vapor products, or components of vapor products in establishments not meeting the above conditions shall be removed prior to December 1, 2013. Any person distributing tobacco ~~products-products~~, tobacco-derived products, vapor products, or components of vapor products through vending machines in violation of this subsection shall be guilty of a Class 2 misdemeanor.

(b2) Internet sales of tobacco products, tobacco-derived products, or vapor products. – A person engaged in the sale of tobacco products, tobacco-derived products, vapor products, or components of vapor products through the Internet or other remote sales methods shall perform an age verification through an independent, third-party age verification service that compares information available from public records to the personal information entered by the individual during the ordering process to establish that the individual ordering the tobacco products, tobacco-derived products, vapor products, or components of vapor products is 18 years of age or older.

(c) Purchase by persons under the age of 18 years. – If any person under the age of 18 years purchases or accepts receipt, or attempts to purchase or accept receipt, of tobacco ~~products-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, or presents or offers to any person any purported proof of age which is false, fraudulent, or not actually his or her own, for the purpose of purchasing or receiving any tobacco ~~product-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, the person shall be guilty of a Class 2 ~~misdemeanor-misdemeanor~~; provided, however, that it shall not be unlawful for an employee to purchase or accept receipt of tobacco products, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers when required in the performance of the employee's duties.

(d) ~~Send or assist~~ Sending or assisting person less than 18 years to purchase or receive tobacco ~~product-products~~, tobacco-derived products, vapor products, or cigarette wrapping papers. – If any person shall send a person less than 18 years of age to purchase, acquire, receive, or attempt to purchase, acquire, or receive tobacco ~~products-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, or if any person shall aid or abet a person who is less than 18 years of age in purchasing, acquiring, or receiving or attempting to purchase, acquire, or receive tobacco ~~products-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, the person shall be guilty of a Class 2 misdemeanor; provided, however, persons under the age of 18 may be enlisted by police or local sheriffs' departments to test compliance if the testing is under the direct supervision of that law enforcement department and written parental consent is provided; provided further, that the Department of Health and Human Services shall have the authority, pursuant to a written plan prepared by the Secretary of Health and Human Services, to use persons under 18 years of age in annual, random, unannounced inspections, provided that prior written parental consent is given for the involvement of these persons and that the inspections are conducted for the sole purpose of preparing a scientifically and

1 methodologically valid statistical study of the extent of success the State has achieved in
2 reducing the availability of tobacco products to persons under the age of 18, and preparing any
3 report to the extent required by section 1926 of the federal Public Health Service Act (42 USC
4 § 300x-26).

5 (e) Statewide uniformity. – It is the intent of the General Assembly to prescribe this
6 uniform system for the regulation of tobacco ~~products~~ products, tobacco-derived products,
7 vapor products, and cigarette wrapping papers to ensure the eligibility for and receipt of any
8 federal funds or grants that the State now receives or may receive relating to the provisions of
9 G.S. 14-313. To ensure uniformity, no political subdivisions, boards, or agencies of the State
10 nor any county, city, municipality, municipal corporation, town, township, village, nor any
11 department or agency thereof, may enact ordinances, rules or regulations concerning the sale,
12 distribution, display or promotion of (i) tobacco products or cigarette wrapping papers on or
13 after September 1, ~~1995~~ 1995, or (ii) tobacco-derived products or vapor products on or after
14 December 1, 2013. This subsection does not apply to the regulation of vending machines, nor
15 does it prohibit the Secretary of Revenue from adopting rules with respect to the administration
16 of the tobacco products taxes levied under Article 2A of Chapter 105 of the General Statutes.

17 (f) Deferred prosecution. – Notwithstanding G.S. 15A-1341(a1), any person charged
18 with a misdemeanor under this section shall be qualified for deferred prosecution pursuant to
19 Article 82 of Chapter 15A of the General Statutes provided the defendant has not previously
20 been placed on probation for a violation of this section and so states under oath."

21 **SECTION 2.** If any provision of this act or its application is held invalid, the
22 invalidity does not affect other provisions or applications of this act that can be given effect
23 without the invalid provisions or application, and to this end the provisions of this act are
24 severable.

25 **SECTION 3.** This act becomes effective December 1, 2013, and applies to offenses
26 committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 530
PROPOSED COMMITTEE SUBSTITUTE S530-CSTK-24 [v.1]

4/30/2013 3:00:19 PM

Short Title: Prohibit E-Cigarette Sales to Minors.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO PROHIBIT THE DISTRIBUTION OF TOBACCO-DERIVED PRODUCTS
AND VAPOR PRODUCTS TO MINORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-313 reads as rewritten:

"Article 39.

"Protection of Minors.

"§ 14-313. Youth access to tobacco ~~products~~ products, tobacco-derived products, vapor products, and cigarette wrapping papers.

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

(1) Distribute. – To sell, furnish, give, or provide tobacco products, tobacco-derived products, or vapor products, including tobacco ~~products~~ samples, or cigarette wrapping papers to the ultimate consumer.

(2) Proof of age. – A drivers license or other photographic identification that includes the bearer's date of birth that purports to establish that the person is 18 years of age or older.

(3) Sample. – A tobacco ~~product~~ product, tobacco-derived product, or vapor product distributed to members of the general public at no cost for the purpose of promoting the product.

(3a) Tobacco-derived product. – Any noncombustible product derived from tobacco that contains nicotine and is intended for human consumption, whether chewed, absorbed, dissolved, ingested, or by other means. This term does not include a vapor product or any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.

(4) Tobacco product. – Any product that contains tobacco and is intended for human consumption. The term does not include a tobacco-derived product or a vapor product.

(5) Vapor product. – Any noncombustible product containing nicotine that employs a mechanical heating element, battery, or electronic circuit, regardless of shape or size and that can be used to heat a liquid nicotine solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe. The term does not include any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.



(b) Sale or distribution to persons under the age of 18 years. – If any person shall distribute, or aid, assist, or abet any other person in distributing tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers to any person under the age of 18 years, or if any person shall purchase tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers on behalf of a ~~person, less than~~ person under the age of 18 years, the person shall be guilty of a Class 2 misdemeanor; provided, however, that it shall not be unlawful to distribute tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers to an employee when required in the performance of the employee's duties. Retail distributors of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall prominently display near the point of sale a sign in letters at least five-eighths of an inch high which states the following:

N.C. LAW STRICTLY PROHIBITS

THE PURCHASE OF TOBACCO ~~PRODUCTS~~PRODUCTS, TOBACCO-DERIVED
PRODUCTS, VAPOR PRODUCTS, AND CIGARETTE WRAPPING PAPERS.

BY PERSONS UNDER THE AGE OF 18.

PROOF OF AGE REQUIRED.

Failure to post the required sign shall be an infraction punishable by a fine of twenty-five dollars (\$25.00) for the first offense and seventy-five dollars (\$75.00) for each succeeding offense.

A person engaged in the sale of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Retail distributors of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall train their sales employees in the requirements of this law. Proof of any of the following shall be a defense to any action brought under this subsection:

- (1) The defendant demanded, was shown, and reasonably relied upon proof of age in the case of a retailer, or any other documentary or written evidence of age in the case of a nonretailer.
- (2) The defendant relied on the electronic system established and operated by the Division of Motor Vehicles pursuant to G.S. 20-37.02.
- (3) The defendant relied on a biometric identification system that demonstrated (i) the purchaser's age to be at least the required age for the purchase and (ii) the purchaser had previously registered with the seller or seller's agent a drivers license, a special identification card issued under G.S. 20-377.7, a military identification card, or a passport showing the purchaser's date of birth and bearing a physical description of the person named on the card.

(b1) ~~Vending machines.~~ Distribution of tobacco products, tobacco-derived products, or vapor products. – Tobacco ~~products-products,~~ tobacco-derived products, vapor products, or components of vapor products shall not be distributed in vending machines; provided, however, vending machines distributing tobacco ~~products-products,~~ tobacco-derived products, vapor products, or components of vapor products are permitted (i) in any establishment which is open

only to persons 18 years of age and older; or (ii) in any establishment if the vending machine is under the continuous control of the owner or licensee of the premises or an employee thereof and can be operated only upon activation by the owner, licensee, or employee prior to each purchase and the vending machine is not accessible to the public when the establishment is closed. The owner, licensee, or employee shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Proof that the defendant demanded, was shown, and reasonably relied upon proof of age shall be a defense to any action brought under this subsection. Vending machines distributing tobacco products in establishments not meeting the above conditions shall be removed prior to December 1, 1997. Vending machines distributing tobacco-derived products, vapor products, or components of vapor products in establishments not meeting the above conditions shall be removed prior to December 1, 2013. Any person distributing tobacco ~~products-products, tobacco-derived products, vapor products, or components of vapor products~~ through vending machines in violation of this subsection shall be guilty of a Class 2 misdemeanor.

(b2) Internet sales of tobacco products, tobacco-derived products, or vapor products. – A person engaged in the sale of tobacco products, tobacco-derived products, vapor products, or components of vapor products through the Internet or other remote sales methods shall perform an age verification through an independent, third-party age verification service that compares information available from public records to the personal information entered by the individual during the ordering process to establish that the individual ordering the tobacco products, tobacco-derived products, vapor products, or components of vapor products is 18 years of age or older.

(c) Purchase by persons under the age of 18 years. – If any person under the age of 18 years purchases or accepts receipt, or attempts to purchase or accept receipt, of tobacco ~~products-products, tobacco-derived products, vapor products, components of vapor products,~~ or cigarette wrapping papers, or presents or offers to any person any purported proof of age which is false, fraudulent, or not actually his or her own, for the purpose of purchasing or receiving any tobacco ~~product-products, tobacco-derived products, vapor products, components of vapor products,~~ or cigarette wrapping papers, the person shall be guilty of a Class 2 ~~misdemeanor-misdemeanor~~; provided, however, that it shall not be unlawful for an employee to purchase or accept receipt of tobacco products, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers when required in the performance of the employee's duties.

(d) ~~Send or assist~~ Sending or assisting person less than 18 years to purchase or receive tobacco ~~product-products, tobacco-derived products, vapor products, or cigarette wrapping papers.~~ – If any person shall send a person less than 18 years of age to purchase, acquire, receive, or attempt to purchase, acquire, or receive tobacco ~~products-products, tobacco-derived products, vapor products, components of vapor products,~~ or cigarette wrapping papers, or if any person shall aid or abet a person who is less than 18 years of age in purchasing, acquiring, or receiving or attempting to purchase, acquire, or receive tobacco ~~products-products, tobacco-derived products, vapor products, components of vapor products,~~ or cigarette wrapping papers, the person shall be guilty of a Class 2 misdemeanor; provided, however, persons under the age of 18 may be enlisted by police or local sheriffs' departments to test compliance if the testing is under the direct supervision of that law enforcement department and written parental consent is provided; provided further, that the Department of Health and Human Services shall have the authority, pursuant to a written plan prepared by the Secretary of Health and Human Services, to use persons under 18 years of age in annual, random, unannounced inspections, provided that prior written parental consent is given for the involvement of these persons and that the inspections are conducted for the sole purpose of preparing a scientifically and

1 methodologically valid statistical study of the extent of success the State has achieved in
2 reducing the availability of tobacco products to persons under the age of 18, and preparing any
3 report to the extent required by section 1926 of the federal Public Health Service Act (42 USC
4 § 300x-26).

5 (e) Statewide uniformity. – It is the intent of the General Assembly to prescribe this
6 uniform system for the regulation of tobacco ~~products~~ products, tobacco-derived products,
7 vapor products, and cigarette wrapping papers to ensure the eligibility for and receipt of any
8 federal funds or grants that the State now receives or may receive relating to the provisions of
9 G.S. 14-313. To ensure uniformity, no political subdivisions, boards, or agencies of the State
10 nor any county, city, municipality, municipal corporation, town, township, village, nor any
11 department or agency thereof, may enact ordinances, rules or regulations concerning the sale,
12 distribution, display or promotion of (i) tobacco products or cigarette wrapping papers on or
13 after September 1, ~~1995~~ 1995, or (ii) tobacco-derived products or vapor products on or after
14 December 1, 2013. This subsection does not apply to the regulation of vending machines, nor
15 does it prohibit the Secretary of Revenue from adopting rules with respect to the administration
16 of the tobacco products taxes levied under Article 2A of Chapter 105 of the General Statutes.

17 (f) Deferred prosecution. – Notwithstanding G.S. 15A-1341(a1), any person charged
18 with a misdemeanor under this section shall be qualified for deferred prosecution pursuant to
19 Article 82 of Chapter 15A of the General Statutes provided the defendant has not previously
20 been placed on probation for a violation of this section and so states under oath."

21 **SECTION 2.** If any provision of this act or its application is held invalid, the
22 invalidity does not affect other provisions or applications of this act that can be given effect
23 without the invalid provisions or application, and to this end the provisions of this act are
24 severable.

25 **SECTION 3.** This act becomes effective December 1, 2013, and applies to offenses
26 committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 530

Short Title: Prohibit E-Cigarette Sales to Minors.

(Public)

Sponsors: Senators Goolsby (Primary Sponsor); Kinnaird, Meredith, and Woodard.

Referred to: Health Care.

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO PROHIBIT THE DISTRIBUTION OF TOBACCO-DERIVED PRODUCTS
AND VAPOR PRODUCTS TO MINORS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 14-313 reads as rewritten:

"Article 39.

"Protection of Minors.

"§ 14-313. Youth access to tobacco ~~products~~ products, tobacco-derived products, vapor products, and cigarette wrapping papers.

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

(1) Distribute. – To sell, furnish, give, or provide tobacco products, tobacco-derived products, or vapor products, including tobacco ~~products~~ samples, or cigarette wrapping papers to the ultimate consumer.

(2) Proof of age. – A drivers license or other photographic identification that includes the bearer's date of birth that purports to establish that the person is 18 years of age or older.

(3) Sample. – A tobacco ~~product~~ product, tobacco-derived product, or vapor product distributed to members of the general public at no cost for the purpose of promoting the product.

(3a) Tobacco-derived product. – Any noncombustible product derived from tobacco that contains nicotine and is intended for human consumption, whether chewed, absorbed, dissolved, ingested, or by other means. This term does not include a vapor product or any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.

(4) Tobacco product. – Any product that contains tobacco and is intended for human consumption. The term does not include a tobacco-derived product or a vapor product.

(5) Vapor product. – Any noncombustible product containing nicotine that employs a mechanical heating element, battery, or electronic circuit, regardless of shape or size and that can be used to heat a liquid nicotine solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe. The term does not include any product regulated by the United States Food and Drug Administration under Chapter V of the federal Food, Drug, and Cosmetic Act.



(b) Sale or distribution to persons under the age of 18 years. – If any person shall distribute, or aid, assist, or abet any other person in distributing tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers to any person under the age of 18 years, or if any person shall purchase tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers on behalf of a ~~person, less than~~ person under the age of 18 years, the person shall be guilty of a Class 2 misdemeanor; provided, however, that it shall not be unlawful to distribute tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers to an employee when required in the performance of the employee's duties. Retail distributors of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall prominently display near the point of sale a sign in letters at least five-eighths of an inch high which states the following:

N.C. LAW STRICTLY PROHIBITS

THE PURCHASE OF TOBACCO ~~PRODUCTS-PRODUCTS,~~ TOBACCO-DERIVED
PRODUCTS, VAPOR PRODUCTS, AND CIGARETTE WRAPPING PAPERS.

BY PERSONS UNDER THE AGE OF 18.

PROOF OF AGE REQUIRED.

Failure to post the required sign shall be an infraction punishable by a fine of twenty-five dollars (\$25.00) for the first offense and seventy-five dollars (\$75.00) for each succeeding offense.

A person engaged in the sale of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Retail distributors of tobacco ~~products-products,~~ tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers shall train their sales employees in the requirements of this law. Proof of any of the following shall be a defense to any action brought under this subsection:

- (1) The defendant demanded, was shown, and reasonably relied upon proof of age in the case of a retailer, or any other documentary or written evidence of age in the case of a nonretailer.
- (2) The defendant relied on the electronic system established and operated by the Division of Motor Vehicles pursuant to G.S. 20-37.02.
- (3) The defendant relied on a biometric identification system that demonstrated (i) the purchaser's age to be at least the required age for the purchase and (ii) the purchaser had previously registered with the seller or seller's agent a drivers license, a special identification card issued under G.S. 20-377.7, a military identification card, or a passport showing the purchaser's date of birth and bearing a physical description of the person named on the card.

(b1) ~~Vending machines.~~ Distribution of tobacco products, tobacco-derived products, or vapor products. – Tobacco ~~products-products,~~ tobacco-derived products, vapor products, or components of vapor products shall not be distributed in vending machines; provided, however, vending machines distributing tobacco ~~products-products,~~ tobacco-derived products, vapor products, or components of vapor products are permitted (i) in any establishment which is open

only to persons 18 years of age and older; or (ii) in any establishment if the vending machine is under the continuous control of the owner or licensee of the premises or an employee thereof and can be operated only upon activation by the owner, licensee, or employee prior to each purchase and the vending machine is not accessible to the public when the establishment is closed. The owner, licensee, or employee shall demand proof of age from a prospective purchaser if the person has reasonable grounds to believe that the prospective purchaser is under 18 years of age. Failure to demand proof of age as required by this subsection is a Class 2 misdemeanor if in fact the prospective purchaser is under 18 years of age. Proof that the defendant demanded, was shown, and reasonably relied upon proof of age shall be a defense to any action brought under this subsection. Vending machines distributing tobacco products in establishments not meeting the above conditions shall be removed prior to December 1, 1997. Vending machines distributing tobacco-derived products, vapor products, or components of vapor products in establishments not meeting the above conditions shall be removed prior to December 1, 2013. Any person distributing tobacco ~~products-products~~, tobacco-derived products, vapor products, or components of vapor products through vending machines in violation of this subsection shall be guilty of a Class 2 misdemeanor.

(b2) Internet sales of tobacco products, tobacco-derived products, or vapor products. – A person engaged in the sale of tobacco products, tobacco-derived products, vapor products, or components of vapor products through the Internet or other remote sales methods shall perform an age verification through an independent, third-party age verification service that compares information available from public records to the personal information entered by the individual during the ordering process to establish that the individual ordering the tobacco products, tobacco-derived products, vapor products, or components of vapor products is 18 years of age or older.

(c) Purchase by persons under the age of 18 years. – If any person under the age of 18 years purchases or accepts receipt, or attempts to purchase or accept receipt, of tobacco ~~products-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, or presents or offers to any person any purported proof of age which is false, fraudulent, or not actually his or her own, for the purpose of purchasing or receiving any tobacco ~~product-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, the person shall be guilty of a Class 2 ~~misdemeanor-misdemeanor~~; provided, however, that it shall not be unlawful for an employee to purchase or accept receipt of tobacco products, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers when required in the performance of the employee's duties.

(d) ~~Send or assist~~ Sending or assisting person less than 18 years to purchase or receive tobacco ~~product-products~~, tobacco-derived products, vapor products, or cigarette wrapping papers. – If any person shall send a person less than 18 years of age to purchase, acquire, receive, or attempt to purchase, acquire, or receive tobacco ~~products-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, or if any person shall aid or abet a person who is less than 18 years of age in purchasing, acquiring, or receiving or attempting to purchase, acquire, or receive tobacco ~~products-products~~, tobacco-derived products, vapor products, components of vapor products, or cigarette wrapping papers, the person shall be guilty of a Class 2 misdemeanor; provided, however, persons under the age of 18 may be enlisted by police or local sheriffs' departments to test compliance if the testing is under the direct supervision of that law enforcement department and written parental consent is provided; provided further, that the Department of Health and Human Services shall have the authority, pursuant to a written plan prepared by the Secretary of Health and Human Services, to use persons under 18 years of age in annual, random, unannounced inspections, provided that prior written parental consent is given for the involvement of these persons and that the inspections are conducted for the sole purpose of preparing a scientifically and

1 methodologically valid statistical study of the extent of success the State has achieved in
2 reducing the availability of tobacco products to persons under the age of 18, and preparing any
3 report to the extent required by section 1926 of the federal Public Health Service Act (42 USC
4 § 300x-26).

5 (e) Statewide uniformity. – It is the intent of the General Assembly to prescribe this
6 uniform system for the regulation of tobacco ~~products~~ products, tobacco-derived products,
7 vapor products, and cigarette wrapping papers to ensure the eligibility for and receipt of any
8 federal funds or grants that the State now receives or may receive relating to the provisions of
9 G.S. 14-313. To ensure uniformity, no political subdivisions, boards, or agencies of the State
10 nor any county, city, municipality, municipal corporation, town, township, village, nor any
11 department or agency thereof, may enact ordinances, rules or regulations concerning the sale,
12 distribution, display or promotion of (i) tobacco products or cigarette wrapping papers on or
13 after September 1, ~~1995~~, or (ii) tobacco-derived products or vapor products on or after
14 December 1, 2013. This subsection does not apply to the regulation of vending machines, nor
15 does it prohibit the Secretary of Revenue from adopting rules with respect to the administration
16 of the tobacco products taxes levied under Article 2A of Chapter 105 of the General Statutes.

17 (f) Deferred prosecution. – Notwithstanding G.S. 15A-1341(a1), any person charged
18 with a misdemeanor under this section shall be qualified for deferred prosecution pursuant to
19 Article 82 of Chapter 15A of the General Statutes provided the defendant has not previously
20 been placed on probation for a violation of this section and so states under oath."

21 **SECTION 2.** This act becomes effective December 1, 2013, and applies to
22 offenses committed on or after that date.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Jane Baker Sharon Keane	NC State Board of Examiners for Nursing Home Administration CAA
Joann Stevens	NCNA
Dan Sams	NA
Tom Fitzer	FSD
21 SDA	BCI
Heather Densmore	Merck
Julia Adams	The Arc NC/NCARF
BILL SCOGGIN	TS
GENE ATENWORTH	NCS
Chris Valenti	Cigar Association of America
Mrs. Shellen	BSK
Sarah Rothacker	Brubaker ASSOC.
Jon Carr	Jordan Prie
Alex Badger	CSS
JAKE PARKER	NCFB
P.G.P.	"
Pat Hahn	TRC

09-21-201

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Conye Dunn	DRNC
Anngiese Dolph	dolph Law
Anthony Ch	R. L. & Assoc.
Denn BUNO	MWC
Will Branthorn	MWC
Sandra Farmer	BIANC
Chuck Stone	SEANC
Tony Rpt	MWC
Scott Sciterra	CITIZEN
Emelyn Dawborne	ETOR

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Richard Carlton	alt
TJ Bragbee	NP
Bob Phillips	CCNC
William Lamore Jr	MEMS
Matt Wolfe	PPAB

**Senate Committee on Health Care
Wednesday, May 8, 2013, 11:00 AM
544 Legislative Office Building**

Senator Ralph Hise, Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages and Sergeants-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 321	Contain Counties' Inmate Medical Costs.	Senator J. Davis Senator Newton Senator Goolsby
SB 132	Health Curriculum/Preterm Birth.	Senator Daniel Senator Tillman Senator Randleman
SB 542	Drug Testing For LTC Applicants & Employees.	Senator Cook Senator Jackson Senator Rabin

Adjournment

**Senate Committee on Health Care
Wednesday, May 8, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on May 8, 2013, in Room 544 of the Legislative Office Building. Eighteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise called the meeting to order by recognizing the Pages—Olivia de Araujo of Wayne County, Gabbie Holmes of Lee County, Kristen Marrow of Washington County, and Jordan Thomas of Wake County; and the Sergeants-at-Arms—Donna Blake, Billy Fritscher, Ed Kesler, Ashley Mickens, and Steve Wilson.

Senator Hise recognized Senator J. Davis to explain Senate Bill 321 – Contain Counties' Inmate Medical Costs. Senator J. Davis moved for adoption of the PCS for Senate Bill 321. The motion to adopt the PCS passed and Senator J. Davis explained the bill and took questions from committee members. Hugh Tilson, Vice President of the NC Hospital Association spoke briefly. Senator Rabin moved for a favorable report to the PCS, unfavorable to the original bill. The PCS passed.

Senator Hise recognized Senator Cook to present Senate Bill 542 – Drug Testing for LTC Applicants & Employees. Senator Tarte offered an amendment and was recognized to explain the amendment. Senator Tarte moved for an adoption of the amendment; the amendment passed. Senator Cook explained the amended bill. Senator Rabin moved for a favorable report of the bill as amended, unfavorable as to the original bill, rolled into a PCS. The amended bill passed.

Senator Hise recognized Senator Daniel to present Senate Bill 132 – Health Curriculum/Preterm Birth. Senator Tucker moved for adoption of the PCS for Senate Bill 132. The motion to adopt the PCS passed and Senator Daniel explained the bill. Senator Randleman spoke briefly on the bill. Dr. Marty McCaffrey, MD, Neonatologist; Professor of Pediatrics at UNC-Chapel Hill; member of the NC Child Fatality Task Force; and Director of the Perinatal Quality Collaborative of North Carolina (PQCNC) was recognized and spoke in support of Senate Bill 132.

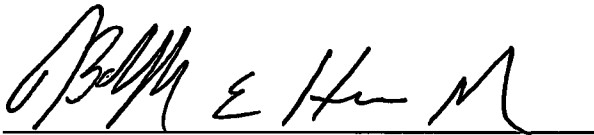
Dr. David Grimes, Clinical Professor in the Department of Obstetrics and Gynecology at UNC-Chapel Hill was recognized and spoke against Senate Bill 132. Kay Phillips, CEO, Adolescent Pregnancy Prevention Campaign of North Carolina was recognized and spoke against Senate Bill 132.

Senator Robinson was recognized to send forth and explain an amendment. Senator Barefoot was recognized to speak, and he referenced a curriculum vitae of and letter from John M. Thorp, Jr., M.D., in support of the bill, which had been distributed earlier to committee members.

Senator Robinson spoke again on her amendment. Senator Daniel asked the committee to vote against the amendment and answered questions from Senators Tucker, J. Davis, and Stein. Senator Hise asked for a vote on the amendment; the amendment failed. Senator Tarte moved for a vote on Senate Bill 132. The bill was approved.

The meeting adjourned at 11:53 AM.

After adjournment, Laura McGee, lobbyist with the North Carolina Values Coalition, entered a written statement into the record of the committee meeting.

A handwritten signature in cursive script, appearing to read "Ralph Hise", written over a horizontal line.

Senator Ralph Hise, Chair
Presiding

A handwritten signature in cursive script, appearing to read "Susan Fanning", written over a horizontal line.

Susan Fanning, Committee Clerk

Principal Clerk _____
Reading Clerk _____

Corrected #2: S 542 has been added.

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	May 8, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
SB 321	Contain Counties' Inmate Medical Costs.	Senator J. Davis Senator Newton Senator Goolsby
SB 132	Health Curriculum/Preterm Birth.	Senator Daniel Senator Tillman Senator Randleman
SB 542	Drug Testing For LTC Applicants & Employees.	Senator Cook Senator Jackson Senator Rabin

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, May 08, 2013

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

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

SB 321	Contain Counties Inmate Medical Costs. Draft Number: S321-PCS15265-TK-28 Sequential Referral: None Recommended Referral: None Long Title Amended: No
SB 542	Drug Testing For LTC Applicants & Employees. Draft Number: S542-PCS15266-SH-16 Sequential Referral: None Recommended Referral: None Long Title Amended: No

TOTAL REPORTED: 2

Senator James Davis will handle SB 321
Senator Bill Cook will handle SB 542



* C M R 5 2 6 - V - 1 *

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, May 08, 2013

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

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

SB 132

Health Curriculum/Preterm Birth.

Draft Number: S132-PCS75317-TB-18

Sequential Referral: None

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Senator Warren Daniel will handle SB 132



* C M R 5 2 0 - V - 1 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 321

Short Title: Contain Counties' Inmate Medical Costs. (Public)

Sponsors: Senators J. Davis, Newton, Goolsby (Primary Sponsors); Bingham, Clark, and Rabin.

Referred to: Health Care.

March 14, 2013

A BILL TO BE ENTITLED
AN ACT TO CAP REIMBURSEMENT BY COUNTIES FOR MEDICAL SERVICES
PROVIDED TO INMATES IN COUNTY JAILS AND TO ALLOW COUNTIES TO
UTILIZE MEDICAID FOR ELIGIBLE PRISONERS.

The General Assembly of North Carolina enacts:

SECTION 1. Counties shall reimburse those providers and facilities providing approved inmate medical services to inmates in local confinement facilities the lesser amount of either a rate of seventy percent (70%) of the provider's then-current prevailing charge or two times the then-current Medicaid rate for any given service. Each county shall have the right to audit any given provider to determine the actual prevailing charge to ensure compliance with this provision.

This section does apply to vendors providing services that are not billed on a fee-for-service basis, such as temporary staffing. Nothing in this section shall preclude a county from contracting with a provider for services at rates that provide greater documentable cost avoidance for the county than do the rates contained in this section or at rates that are less favorable to the county but that will ensure the continued access to care.

SECTION 2. G.S. 153A-225(a) reads as rewritten:

"(a) Each unit that operates a local confinement facility shall develop a plan for providing medical care for prisoners in the facility. ~~The plan plan:~~

- (1) Shall be designed to protect the health and welfare of the prisoners and to avoid the spread of contagious disease;
- (2) Shall provide for medical supervision of prisoners and emergency medical care for prisoners to the extent necessary for their health and welfare;
- (3) Shall provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal ~~diseases-diseases; and~~
- (4) May utilize Medicaid coverage for eligible prisoners, provided that the plan includes a reimbursement to the State of the State portion of the costs, including the costs of the services provided and any administrative costs to the State's Medicaid program.

The unit shall develop the plan in consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society. The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners. Upon a



1 determination that the plan is adequate to protect the health and welfare of the prisoners, the
2 plan must be adopted by the governing body.

3 As a part of its plan, each unit may establish fees of not more than twenty dollars (\$20.00)
4 per incident for the provision of nonemergency medical care to prisoners. In establishing fees
5 pursuant to this section, each unit shall establish a procedure for waiving fees for indigent
6 prisoners."

7 **SECTION 3.** This act becomes effective July 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2013

S

D

SENATE BILL 321

PROPOSED COMMITTEE SUBSTITUTE S321-CSTK-28 [v.2]

5/7/2013 5:33:37 PM

Short Title: Contain Counties' Inmate Medical Costs.

(Public)

Sponsors:

Referred to:

March 14, 2013

A BILL TO BE ENTITLED

AN ACT TO CAP REIMBURSEMENT BY COUNTIES FOR MEDICAL SERVICES PROVIDED TO INMATES IN COUNTY JAILS AND TO ALLOW COUNTIES TO UTILIZE MEDICAID FOR ELIGIBLE PRISONERS.

The General Assembly of North Carolina enacts:

SECTION 1. Counties shall reimburse those providers and facilities providing approved inmate medical services to inmates in local confinement facilities the lesser amount of either a rate of seventy percent (70%) of the provider's then-current prevailing charge or two times the then-current Medicaid rate for any given service. Each county shall have the right to audit any given provider to determine the actual prevailing charge to ensure compliance with this provision.

This section does apply to vendors providing services that are not billed on a fee-for-service basis, such as temporary staffing. Nothing in this section shall preclude a county from contracting with a provider for services at rates that provide greater documentable cost avoidance for the county than do the rates contained in this section or at rates that are less favorable to the county but that will ensure the continued access to care.

SECTION 2. G.S. 153A-225(a) reads as rewritten:

"(a) Each unit that operates a local confinement facility shall develop a plan for providing medical care for prisoners in the facility. The plan-plan:

- (1) Shall be designed to protect the health and welfare of the prisoners and to avoid the spread of contagious disease;
- (2) Shall provide for medical supervision of prisoners and emergency medical care for prisoners to the extent necessary for their health and welfare;
- (3) Shall provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal ~~diseases~~; and
- (4) May utilize Medicaid coverage for inpatient hospitalization for eligible prisoners, provided that the plan includes a reimbursement to the State of the State portion of the costs, including the costs of the services provided and any administrative costs to the State's Medicaid program.

The unit shall develop the plan in consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society. The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners. Upon a determination that the plan is adequate to protect the health and welfare of the prisoners, the plan must be adopted by the governing body.

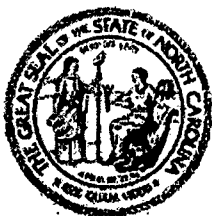


* S 3 2 1 - C S T K - 2 8 - V - 2 *

1 As a part of its plan, each unit may establish fees of not more than twenty dollars (\$20.00)
2 per incident for the provision of nonemergency medical care to prisoners. In establishing fees
3 pursuant to this section, each unit shall establish a procedure for waiving fees for indigent
4 prisoners."

5 **SECTION 3.** In preparation for the July 1, 2014 effective date of Section 2 of this
6 act, the Department of Public Safety (DPS) shall work with the counties to prepare for the
7 change made to G.S. 153A-225(a)(4) made in Section 2. DPS shall facilitate the counties' use
8 of the existing system in place between DPS and the Department of Health and Human
9 Services that enables DPS to utilize Medicaid coverage for inpatient hospitalization for eligible
10 individuals.

11 **SECTION 4.** Section 2 of this act becomes effective July 1, 2014. The remainder
12 of this act becomes effective July 1, 2013.



SENATE BILL 321: Contain Counties' Inmate Medical Costs

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sens. J. Davis, Newton, Goolsby
Analysis of: PCS to First Edition
S321-CSTK-28

Date: May 7, 2013
Prepared by: Amy Jo Johnson
Committee Counsel

SUMMARY: *The PCS to Senate Bill 321 directs that counties are to reimburse providers and facilities which provide inmate medical services the lesser amount of either a rate of 70% of the providers prevailing charge or two times the Medicaid rate for any given services. The PCS would allow counties to utilize Medicaid coverage for inpatient hospitalization for eligible prisoners, so long as the plan to do so includes a reimbursement to the State of the State portion of the costs.*

[As introduced, this bill was identical to H448, as introduced by Reps. Lucas, Glazier, Floyd, Szoka, which is currently in House Health and Human Services, if favorable, Appropriations.]

CURRENT LAW:

Federal law provides that the federal government will not reimburse states for medical care provided to "any individual who is an inmate of a public institution." 42 USCA 1396d. However, federal law does provide an exception that allows for payments for medical care provided "during that part of the month in which the individual is not an inmate of a public institution." 42 CFR 453.1008. This exception applies when an inmate is treated in an inpatient hospital setting that is not part of the corrections system.

BILL ANALYSIS:

Section 1 of the PCS to Senate Bill 321 directs that counties are to reimburse providers and facilities which provide inmate medical services the lesser amount of either a rate of 70% of the providers prevailing charge or two times the Medicaid rate for any given services. Counties have the right to audit any provider to determine the actual prevailing charge. **Section 1** of the bill does not apply to vendors providing services that are not billed on a fee-for-service basis. Counties may contract with providers at rates more favorable to the county than provided in the bill or rates that are less favorable but ensure continued access to care.

Section 2 of the PCS adds the utilization of Medicaid coverage for inpatient hospitalization of prisoners to the lists of items that the units which are operating a local confinement facility are able to include in their plans for providing medical care to prisoners in the facility. Local confinement facilities may use Medicaid coverage for inpatient hospitalization for eligible prisoners, provided the plan includes a reimbursement to the State for the State portion of the medical care costs. This includes the costs of the services provided and any administrative costs to the State's Medicaid program.

Section 3 of the PCS directs the Department of Public Safety (DPS) to work with the counties to prepare for the ability to utilize Medicaid coverage for inpatient hospitals of prisoners.

EFFECTIVE DATE: Section 2 of the act becomes effective July 1, 2014. The remainder of the act becomes effective July 1, 2013.



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 542

Short Title: Drug Testing For LTC Applicants & Employees. (Public)

Sponsors: Senators Cook, Jackson, Rabin (Primary Sponsors); and Meredith.

Referred to: Health Care.

April 1, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE LONG-TERM CARE FACILITIES TO REQUIRE APPLICANTS
3 FOR EMPLOYMENT AND CERTAIN EMPLOYEES TO SUBMIT TO DRUG
4 TESTING FOR CONTROLLED SUBSTANCES.

5 The General Assembly of North Carolina enacts:

6 SECTION 1. Article 5 of Chapter 131D of the General Statutes is amended by
7 adding a new section to read:

8 "§ 131D-45. Testing for the presence of controlled substances required for applicants for
9 employment in adult care homes.

10 (a) An offer of employment by an adult care home licensed under this Article to an
11 applicant is conditioned on the applicant's consent to an examination and screening for
12 controlled substances. The examination and screening shall be conducted in accordance with
13 Article 20 of Chapter 95 of the General Statutes. If the results of the applicant's examination
14 and screening indicate the presence of a controlled substance, the adult care home shall not
15 employ the applicant unless the applicant first provides to the adult care home written
16 verification from the applicant's prescribing physician that every controlled substance identified
17 by the examination and screening is prescribed by that physician to treat the applicant's medical
18 or psychological condition. The verification from the physician shall include the name of the
19 controlled substance, the prescribed dosage and frequency, and the condition for which the
20 substance is prescribed. If the result of an applicant's or employee's examination and screening
21 indicates the presence of a controlled substance, the adult care home may require a second
22 examination and screening to verify the results of the prior examination and screening.

23 (b) An adult care home may require random testing for controlled substances as a
24 condition of continued employment. If the adult care home has reasonable grounds to believe
25 that an employee is an abuser of a controlled substance, the adult care home may require that
26 employee to undergo examination and screening for controlled substances as a condition of
27 continued employment.

28 (c) An adult care home and an officer or employee of an adult care home that, in good
29 faith, complies with this section is not liable for the failure of the adult care home to employ or
30 continue the employment of an individual on the basis of the results of an examination and
31 screening of the applicant or employee for controlled substances.

32 (d) An entity and officers and employees of an entity that performs controlled substance
33 testing in accordance with Article 20 of Chapter 95 of the General Statutes shall be immune
34 from civil liability for conducting or failing to conduct the examination and screening if the
35 examination and screening are requested and received in compliance with this section and with
36 Article 20 of Chapter 95 of the General Statutes.



1 (e) The results of an examination and screening conducted at the request of an adult
2 care home in accordance with this section are confidential and not a public record under
3 Chapter 132 of the General Statutes. The adult care home shall maintain the confidentiality of
4 all information related to the examination and screening of an applicant for employment or an
5 individual currently employed by the adult care home."

6 **SECTION 2.** Part 1 of Article 6 of Chapter 131E of the General Statutes is
7 amended by adding a new section to read:

8 **"§ 131E-114.4. Testing for the presence of controlled substances required for applicants**
9 **for employment in nursing homes.**

10 (a) An offer of employment by a nursing home licensed under this Part to an applicant
11 is conditioned on the applicant's consent to an examination and screening for controlled
12 substances. The examination and screening shall be conducted in accordance with Article 20 of
13 Chapter 95 of the General Statutes. If the results of the applicant's examination and screening
14 indicate the presence of a controlled substance, the nursing home shall not employ the applicant
15 unless and until the applicant provides to the nursing home written verification from the
16 applicant's prescribing physician that every controlled substance identified by the examination
17 and screening is prescribed by that physician to treat the applicant's medical or psychological
18 condition. The verification from the physician shall include the name of the controlled
19 substance, the prescribed dosage and frequency, and the condition for which the substance is
20 prescribed. If the result of an applicant's or employee's examination and screening indicate the
21 presence of a controlled substance, the nursing home may require a second examination and
22 screening to verify the results of the prior examination and screening.

23 (b) A nursing home may require random testing for controlled substances as a condition
24 of continued employment. If the nursing home has reasonable grounds to believe that an
25 employee is an abuser of a controlled substance, the nursing home may require that employee
26 to undergo examination and screening for controlled substances as a condition of continued
27 employment.

28 (c) A nursing home and an officer or employee of a nursing home that, in good faith,
29 complies with this section is not liable for the failure of the nursing home to employ or
30 continue the employment of an individual on the basis of the results of an examination and
31 screening of the applicant or employee for controlled substances.

32 (d) An entity and officers and employees of an entity that performs controlled substance
33 testing in accordance with Article 20 of Chapter 95 of the General Statutes shall be immune
34 from civil liability for conducting or failing to conduct the examination and screening if the
35 examination and screening are requested and received in compliance with this section and with
36 Article 20 of Chapter 95 of the General Statutes.

37 (e) The results of an examination and screening conducted at the request of a nursing
38 home in accordance with this section are confidential and not a public record under Chapter
39 132 of the General Statutes. The nursing home shall maintain the confidentiality of all
40 information related to the examination and screening of an applicant for employment or an
41 individual currently employed by the adult care home."

42 **SECTION 3.** This act becomes effective October 1, 2013.



SENATE BILL 542: Drug Testing For LTC Applicants & Employees

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Cook, Jackson, Rabin
Analysis of: First Edition

Date: May 7, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *Senate Bill 542 requires an offer of employment by an adult care home and a nursing home be conditioned on the applicant's consent to an examination and screening for controlled substances and allows random examination and screening as a condition of continued employment.*

CURRENT LAW: Article 20, Chapter 95, pertains to Controlled Substance Examination Regulation. G.S. 95-231 defines the following terms: approved laboratory, controlled substance, controlled substance examination, examiner, examinee, and screening. G.S. 95-232 provides the procedural requirements for the administration of controlled substance examinations. G.S. 95-234 provides that an examiner who violates the provisions of the Article is subject to a civil penalty of up to \$250.

BILL ANALYSIS: Senate Bill 542 requires drug testing for employees of long-term care facilities. Section 1 of the bill adds a new section, G.S. 131D-45, pertaining to adult care homes, and Section 2 of the bill adds a new section, G.S. 131E-114.4, pertaining to nursing homes. Each section contains subsections (a) – (e) which are summarized below.

Subsection (a) requires that an offer of employment in an adult care home or nursing home be conditioned on the applicant's consent to an examination and screening for controlled substances conducted in accordance with Article 20 of Chapter 95. The facility is prohibited from employing an applicant whose examination and screening indicate the presence of a controlled substance, unless the applicant provides to the employer a written verification from the applicant's prescribing physician that every controlled substance identified is prescribed (including dosage and frequency) by the physician to treat the applicant's medical or psychological condition. If the result of an examination and screening indicate the presence of a controlled substance, the employer may require a second examination and screening.

Subsection (b) allows an adult care home and a nursing home to require random testing for controlled substances as a condition of continued employment if the employer has reasonable grounds to believe that an employee is an abuser of a controlled substance.

Subsection (c) provides that if an adult care home or nursing home and an officer or employee of the entity comply with the section in good faith, they are not liable for failure to employ or continue employment of an individual on the basis of the results of an examination and screening.

Subsection (d) provides that an entity that performs controlled substance testing and its officers and employees are immune from civil liability for conducting or failing to conduct the examination and screening if requested and received in compliance with the section and Article 20 of Chapter 95.

Subsection (e) requires the results of the examination and screening to be kept confidential and not to be treated as a public record under Chapter 132 of the General Statutes.

EFFECTIVE DATE: Senate Bill 542 would become effective October 1, 2013.

O. Walker Reagan
Director



Research Division
(919) 733-2578

* S 5 4 2 - S M S H - 3 5 E 1 - V 1 *



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 132

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

S132-ATK-30 [v.2]

Page 1 of 1

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

Date May 8, 2013

Senator Robinson

1 moves to amend the bill on page 1, line 31-33, by rewriting the line to read:

2
3 "i. Teaches about the preventable causes of preterm birth."
4
5

SIGNED

Gladys Robinson
Amendment Sponsor

SIGNED

Robert H. M.
Committee Chair if Senate Committee Amendment

ADOPTED _____

FAILED X

TABLED _____



* S 1 3 2 - A T K - 3 0 - V - 2 *



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 542

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

S542-ASH-5 [v.4]

Page 1 of 2

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

Date May 8, 2013

Senator TATE

1 moves to amend the bill on page 2, lines 5-6, by inserting the following between the lines:

2 "(f) The cost of the examination and screening for controlled substances conducted pursuant
3 to this section shall be paid by the adult care home.";

4
5 and on page 2, lines 41-42, by inserting the following between the lines:

6 "(f) The cost of the examination and screening for controlled substances pursuant to this
7 section shall be paid for by the nursing home.";

8
9
10
11 and on page 1, line 8 by rewriting the line to read:

12 "§ 131D-45. Examination and screening for the presence of controlled substances
13 required for applicants for";

14
15 and on page 1, line 23, by rewriting the line to read:

16 "(b) An adult care home may require random examination and screening for controlled
17 substances as a";

18
19 and on page 1, line 33, by rewriting the line to read:

20 "examination and screening in accordance with Article 20 of Chapter 95 of the General Statutes
21 shall be immune";

22
23 and on page 2, line 8, by rewriting the line to read:

24 "§ 131E-114.4. Examination and screening for the presence of controlled substances
25 required for applicants";

26
27 and on page 2, line 23, by rewriting the line to read:

28 "(b) A nursing home may require random examination and screening for controlled
29 substances as a condition";

30
31 and on page 2, line 33, by rewriting the line to read:



* S 5 4 2 - A S H - 5 - V - 4 *

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 542

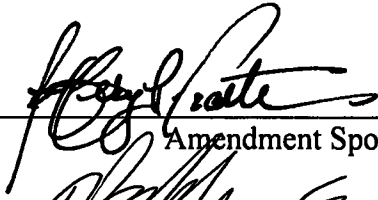
AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S542-ASH-5 [v.4]

Page 2 of 2

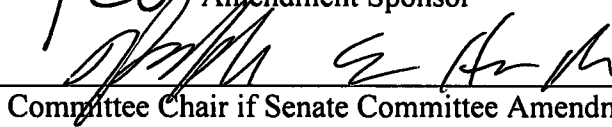
- 1 "examination and screening in accordance with Article 20 of Chapter 95 of the General Statutes
2 shall be immune".

SIGNED _____



Amendment Sponsor

SIGNED _____



Committee Chair if Senate Committee Amendment

ADOPTED _____

☒

FAILED _____

TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2013

S

1

SENATE BILL 132

Short Title: Health Curriculum/Preterm Birth.

(Public)

Sponsors: Senators Daniel, Tillman, Randleman (Primary Sponsors); and Brock.

Referred to: Health Care.

February 26, 2013

A BILL TO BE ENTITLED

AN ACT TO INCLUDE INSTRUCTION IN THE SCHOOL HEALTH EDUCATION PROGRAM ON THE PREVENTABLE CAUSES OF PRETERM BIRTH, INCLUDING INDUCED ABORTION AS A CAUSE OF PRETERM BIRTH IN SUBSEQUENT PREGNANCIES, AS RECOMMENDED BY THE NORTH CAROLINA CHILD FATALITY TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-81(e1)(1) reads as rewritten:

"(e1) School Health Education Program to Be Developed and Administered.

(1) A comprehensive school health education program shall be developed and taught to pupils of the public schools of this State from kindergarten through ninth grade. This program includes age-appropriate instruction in the following subject areas, regardless of whether this instruction is described as, or incorporated into a description of, "family life education", "family health education", "health education", "family living", "health", "healthful living curriculum", or "self-esteem":

- a. Mental and emotional health.
- b. Drug and alcohol abuse prevention.
- c. Nutrition.
- d. Dental health.
- e. Environmental health.
- f. Family living.
- g. Consumer health.
- h. Disease control.
- i. Growth and development.
- j. First aid and emergency care, including the teaching of cardiopulmonary resuscitation (CPR) and the Heimlich maneuver by using hands-on training with mannequins so that students pass a test approved by the American Heart Association, or American Red Cross. Schools shall use for this purpose an instructional program developed by the American Heart Association, the American Red Cross, or other nationally recognized programs that is based on the most current national evidence-based emergency cardiovascular care guidelines for CPR. Schools shall maintain documentation in an electronic database that students have successfully completed CPR instruction to meet Healthy Living Essential Standards. Successful



1 completion of instruction in CPR shall be a requirement for high
2 school graduation by the 2014-2015 school year.

3 k. Preventing sexually transmitted diseases, including HIV/AIDS, and
4 other communicable diseases.

5 l. Reproductive health and safety education. The instruction program
6 shall include information about the preventable causes of preterm
7 birth, including induced abortion as a cause of preterm birth in
8 subsequent pregnancies.

9 m. Bicycle safety.

10 As used in this subsection, "HIV/AIDS" means Human
11 Immunodeficiency Virus/Acquired Immune Deficiency Syndrome."

12 **SECTION 2.** To facilitate the implementation of this act, within 60 days of this act
13 becoming effective and annually thereafter, the Department of Health and Human Services,
14 Division of Public Health, shall provide to the Department of Public Instruction sample
15 educational materials with the most current information available about the preventable causes
16 of preterm birth, including induced abortion as a cause of preterm birth in subsequent
17 pregnancies.

18 **SECTION 3.** This act is effective when it becomes law and applies beginning with
19 the 2013-2014 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2013

S

D

SENATE BILL 132

PROPOSED COMMITTEE SUBSTITUTE S132-CSTB-18 [v.1]

5/7/2013 6:47:59 PM

Short Title: Health Curriculum/Preterm Birth.

(Public)

Sponsors:

Referred to:

February 26, 2013

A BILL TO BE ENTITLED

AN ACT TO INCLUDE INSTRUCTION IN THE SCHOOL HEALTH EDUCATION PROGRAM ON THE PREVENTABLE CAUSES OF PRETERM BIRTH, INCLUDING INDUCED ABORTION AS A CAUSE OF PRETERM BIRTH IN SUBSEQUENT PREGNANCIES, AS RECOMMENDED BY THE NORTH CAROLINA CHILD FATALITY TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-81(e1)(4) reads as rewritten:

"(4) Each local school administrative unit shall provide a reproductive health and safety education program commencing in the seventh grade that includes the following instruction:

- a. Teaches that abstinence from sexual activity outside of marriage is the expected standard for all school-age children.
- b. Presents techniques and strategies to deal with peer pressure and offering positive reinforcement.
- c. Presents reasons, skills, and strategies for remaining or becoming abstinent from sexual activity.
- d. Teaches that abstinence from sexual activity is the only certain means of avoiding out-of-wedlock pregnancy, sexually transmitted diseases when transmitted through sexual contact, including HIV/AIDS, and other associated health and emotional problems.
- e. Teaches that a mutually faithful monogamous heterosexual relationship in the context of marriage is the best lifelong means of avoiding sexually transmitted diseases, including HIV/AIDS.
- f. Teaches the positive benefits of abstinence until marriage and the risks of premarital sexual activity.
- g. Provides opportunities that allow for interaction between the parent or legal guardian and the student.
- h. Provides factually accurate biological or pathological information that is related to the human reproductive system.
- i. Teaches about the preventable causes of preterm birth, including induced abortion as a cause of preterm birth in subsequent pregnancies.

Materials used in this instruction shall be age appropriate for use with students. Information conveyed during the instruction shall be objective and based upon scientific research that is peer reviewed and accepted by



* S 1 3 2 - C S T B - 1 8 - V - 1 *

1 professionals and credentialed experts in the field of sexual health
2 education."

3 **SECTION 2.** To facilitate the implementation of this act, within 60 days of this act
4 becoming effective and annually thereafter, the Department of Health and Human Services,
5 Division of Public Health, shall provide to the Department of Public Instruction sample
6 educational materials with the most current information available about the preventable causes
7 of preterm birth, including induced abortion as a cause of preterm birth in subsequent
8 pregnancies.

9 **SECTION 3.** This act is effective when it becomes law and applies beginning with
10 the 2013-2014 school year.



SENATE BILL 132: Health Curriculum/Preterm Birth

2013-2014 General Assembly

Committee:	Senate Health Care	Date:	May 7, 2013
Introduced by:	Sens. Daniel, Tillman, Randleman	Prepared by:	Amy Jo Johnson
Analysis of:	PCS to First Edition S132-CSTB-18		Committee Counsel

SUMMARY: *The PCS to Senate Bill 132 would require that the reproductive health and safety education, provided as part of a reproductive health and safety education program, include information about the preventable causes of preterm birth, including abortion as a cause of preterm birth in subsequent pregnancies.*

CURRENT LAW:

G.S. 115C-81(e1)(4) outlines the subjects to be taught as part of the reproductive health and safety education program commencing in the seventh grade for public schools.

BILL ANALYSIS:

The PCS for Senate Bill 132 requires that the reproductive health and safety education provided in the public school curriculum include information about the preventable causes of preterm birth, including abortion as a cause of preterm birth in subsequent pregnancies. The PCS locates this requirement under 115C-81(e1)(4), thus making the requirement apply to the reproductive health and safety education program that commences in the seventh grade.

The PCS also requires the Division of Public Health to provide to the Department of Public Instruction sample educational materials with the most current information available about the preventable causes of preterm birth within 60 days of this act becoming effective, and annually thereafter.

EFFECTIVE DATE:

This act is effective when it becomes law and applies beginning with the 2013-2014 school year.

BACKGROUND:

This is a recommendation by the North Carolina Child Fatality Task Force. Its report can be found at the following link:

<http://www.ncleg.net/DocumentSites/Committees/NCCFTF/Reports%20and%20Data/2013%20CFTF%20%20Annual%20Report.pdf>

O. Walker Reagan
Director



Research Division
(919) 733-2578

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

5.8.13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Ellen Essick	DPI
Kay Phillips	APPCNC
Cathy O. Yancey	APPCNC
Joni O'Neil	BEGINNINGS
Brylyn Hawthorne	NCHA, NCAP
Laura McGee	NC Values
Joni Fitzmaurice	NCHA
Shera Reid	SOG/LRS
Karen Lemmons	NCHA Nurse for the Day
Adam Pridmore	NCHA
Christine Craig	Wake Med
Doug Heron	un
MUCH TILSON	NCHA
J. Middleton	Smithsonian
Ken Melton	K.M.A.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

5-8-13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
<i>[Signature]</i>	NCSNA
<i>[Signature]</i>	NCFPC
Annaliese Dolph	Dolph Law
Leanne E. Wmiller	NCSBA
Marty McCaffrey	UNC
Erica Nelson	NCHA
DANIEL VAN LIERE	VADANT HEALTH
Cory Haas	NCHA
Amanda Hoxaker	Trounman Sanders
Adam Sholar	DHHS
Anthony Vellucci	DHHS
Denise Foreman	Wake County
Maeris Gardner	GSK
Lindsay Dalby	GSK
Amy Whited	NUMS
<i>[Signature]</i>	DPI
Nakisha Floyd	DPI

**Senate Committee on Health Care
Wednesday, May 29, 2013, 11:00 AM
544 Legislative Office Building**

Senator Louis Pate, Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 663	Blue Ribbon Comm. Recs./Supportive MH Housing.	Senator Hise
HB 492	Safeguard Qualified Individuals- Medicaid PCS.	Representative Dollar
HB 399	Amend Laws Pertaining to DHHS.-AB	Representative Burr Representative Hollo Representative Avila
HB 459	Chronic Care Coordination Act.	Representative Dollar Representative Murry Representative Hollo Representative Lambeth

Adjournment

**Senate Committee on Health Care
Wednesday, May 29, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on May 29, 2013 in Room 544 of the Legislative Office Building. Sixteen members were present.

Senator Louis Pate presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Ashley Mickens, Steve Wilson, Ed Kesler, Billy Fritscher. He then recognized the Pages assisting with the meeting: Jazmyn Jones of Knightdale, Elaine Kearney of Pinehurst, Antoinette Dyer of Raleigh, Janna Sims of Autryville, Lillie Turlington of Clinton, Andrew Distell of Fayetteville and Thomas McBrayer of Hickory.

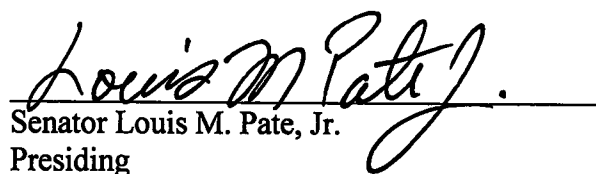
Senator Pate recognized Senator Hise to explain the first bill on the agenda, SB 663 "Blue Ribbon Comm. Recs./Supportive MH." A PCS was offered for the bill; Senator Stein moved to accept the PCS. After Senator Hise finished his explanation of the bill, Senator Wade moved for a favorable report, unfavorable to the original bill, re-referred to Appropriations/Base Budget. The motion carried.

Representative Dollar was asked to explain HB 492 "Safeguard Qualified Individuals-Medicaid PCS." An amendment was offered by Senator Hise; Senator Rabin moved to adopt the amendment. Representative Dollar entertained numerous questions after which Senator Wade moved for a favorable report, unfavorable to the original and re-referred to Appropriations/Base Budget. The motion carried.

Senator Pate then recognized Representative Burr to explain HB 399, "Amend Laws Pertaining to DHHS.-AB." Senator Wade offered an amendment; the amendment was adopted. Senator Rabin then moved for a favorable report as amended, rolled into a PCS and sent to the floor. The motion carried.

Representative Dollar was once again recognized to explain HB 459, "Chronic Care Coordination Act." The PCS was pulled and the original bill was brought before the Committee. Senator Woodard moved for a favorable report and referred to Appropriations/Base Budget. The motion carried.

The meeting adjourned at 11:55 a.m.


Senator Louis M. Pate, Jr.
Presiding


Edna Pearce, Committee Clerk

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, May 29, 2013

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

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

SB 663

Blue Ribbon Comm. Recs./Supportive MH Housing.

Draft Number: S663-PCS35352-MG-18

Sequential Referral: Appropriations/Base Budget

Recommended Referral: None

Long Title Amended: Yes

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

HB 492 (CS#1)

Safeguard Qualified Individuals-Medicaid PCS.

Draft Number: H492-PCS10410-SH-17

Sequential Referral: Appropriations/Base Budget

Recommended Referral: None

Long Title Amended: No

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

HB 399 (CS#2)

Amend Laws Pertaining to DHHS.-AB

Draft Number: H399-PCS10411-TK-40

Sequential Referral: Judiciary II

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 3

Senator Ralph Hise will handle SB 663

Senator Ralph Hise will handle HB 492

Senator Louis Pate will handle HB 399



* C M R 6 6 6 - V - 1 *

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, May 29, 2013

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

FAVORABLE

HB 459

Chronic Care Coordination Act.

Draft Number: None

Sequential Referral: Appropriations/Base Budget

Recommended Referral: None

Long Title Amended: No

TOTAL REPORTED: 1

Senator Ralph Hise will handle HB 459



* C M R 6 6 7 - V - 1 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

1

SENATE BILL 663

Short Title: Blue Ribbon Comm. Recs./Supportive MH Housing. (Public)

Sponsors: Senators Hise (Primary Sponsor); and Pate.

Referred to: Health Care.

April 4, 2013

A BILL TO BE ENTITLED

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE HOUSING
SUBCOMMITTEE OF THE BLUE RIBBON COMMISSION ON TRANSITIONS TO
COMMUNITY LIVING (1) TO REQUIRE THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES TO ESTABLISH A SUPPORTIVE HOUSING PROGRAM AND
AN ASSISTIVE TECHNOLOGY REUTILIZATION PROGRAM FOR INDIVIDUALS
TRANSITIONING FROM INSTITUTIONAL SETTINGS TO INTEGRATED
COMMUNITY-BASED SETTINGS, (2) TO APPROPRIATE FUNDS TO THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE ESTABLISHMENT
AND OPERATION OF THESE PROGRAMS, AND (3) TO CREATE A TRANSITIONS
TO COMMUNITY LIVING HOUSING BUDGET WITHIN THE TRANSITIONS TO
COMMUNITY LIVING FUND TO INTEGRATE INDIVIDUALS WITH MENTAL
ILLNESS INTO COMMUNITY-BASED SUPPORTED HOUSING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO"
means an LME that has been approved by the Department to operate the
1915(b)/(c) Medicaid Waiver."

SECTION 2.(a) Chapter 122C of the General Statutes is amended by adding a new
Article to read:

"Article 1B.

"Transitions to Community Living.

"Part 1. North Carolina Supportive Housing Program.

"§ 122C-20.5. Definitions.

The following definitions apply in this Article:

(1) In-reach activities. – Education and information provided by the Department
or an LME/MCO by individuals who are knowledgeable about community
services and supports to residents of adult care homes or State psychiatric
hospitals about the benefits and financial aspects of clinically appropriate,
community-based supported housing in an integrated setting. The term
includes all of the following: (i) facilitating and accompanying residents'
visits to supported housing apartments, (ii) assessing residents' interest in
supported housing, (iii) exploring and addressing residents' concerns about
moving to supporting housing, (iv) reviewing residents' housing preferences,
and (v) providing opportunities for residents to meet with other individuals
with disabilities who are living, working, and receiving services in integrated



* S 6 6 3 - V - 1 *

1 settings; their families; and community providers. This term does not include
2 education or information provided by adult care homes or State psychiatric
3 hospitals to residents.

4 (2) Institution for mental disease. – As defined in 42 C.F.R. § 435.1009, as from
5 time to time amended, a hospital, nursing facility, or other institution of
6 more than 16 beds that is primarily engaged in providing diagnosis,
7 treatment, or care of individuals with mental diseases, including medical
8 attention, nursing care, and related services. The term does not include an
9 institution for individuals with mental retardation.

10 (3) Individual with serious mental illness or SMI. – An individual who is 18
11 years of age or older with a mental illness or disorder that is described in the
12 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, that
13 impairs or impedes functioning in one or more major areas of living and is
14 unlikely to improve without treatment, services, supports, or all three. The
15 term does not include a primary diagnosis of Alzheimer's disease or
16 dementia.

17 (4) Individual with serious and persistent mental illness or SPMI. – A person
18 who is 18 years of age or older who meets one of the following criteria:

19 a. Has a mental illness or disorder that is so severe and chronic that it
20 prevents or erodes development of functional capacities in primary
21 aspects of daily life such as personal hygiene and self-care, decision
22 making, interpersonal relationships, social transactions, learning, and
23 recreational activities.

24 b. Is receiving Supplemental Security Income or Social Security
25 Disability Income due to mental illness.

26 **"§ 122C-20.6. Department to establish statewide supportive housing program for**
27 **individuals transitioning into community living; purpose.**

28 The Department of Health and Human Services, in consultation with the North Carolina
29 Housing Finance Agency, shall establish and administer a tenant-based rental assistance
30 program known as the North Carolina Supportive Housing Program. The purpose of the
31 program is to transition individuals diagnosed with serious mental illness and serious and
32 persistent mental illness from institutional settings to more integrated community-based
33 settings appropriate to meet their needs. Under the program, the Department, in consultation
34 with the North Carolina Housing Finance Agency and LME/MCOs, shall arrange for program
35 participants to be placed in housing slots available through the program with all the rights and
36 obligations created by a landlord-tenant relationship.

37 **"§ 122C-20.7. Administration of housing subsidies for supportive housing.**

38 The Department may enter into a contract with a private vendor to serve as the housing
39 subsidy administrator for the North Carolina Supportive Housing Program with responsibility
40 for distributing rental vouchers and community living vouchers to program participants based
41 on a formula developed by the Department.

42 **"§ 122C-20.8. Eligibility requirements for NC Supportive Housing Program.**

43 The Commission on Mental Health, Developmental Disabilities, and Substance Abuse
44 Services shall adopt rules to establish eligibility requirements for program. The eligibility
45 requirements shall, at a minimum, include income eligibility requirements and requirements to
46 give priority for program participation and transition services to individuals with SMI or SPMI
47 who are currently residing in institutional settings.

48 **"§ 122C-20.9. In-reach activities for supportive housing.**

49 The Department shall have ongoing responsibility for developing and distributing a list of
50 potentially eligible program participants for each LME/MCO by catchment area. Upon receipt
51 of this information, each LME/MCO shall have ongoing responsibility for prioritizing the list

of individuals to whom it will provide in-reach activities in order to (i) arrange an in-person meeting with potentially eligible participants to determine their eligibility and level of interest and (ii) report back to the Department on the LME/MCO's recommended list of program participants on a monthly basis. Upon receipt of an LME/MCO's recommended list of program participants, the Department shall make a final determination of eligibility.

"§ 122C-20.10. Allocation of supportive housing slots to LME/MCOs.

The Department shall annually determine the number of housing slots to be allocated to each LME/MCO as follows:

- (1) Each year, the Department shall distribute at least fifty percent (50%) of the housing slots available through this program equally among all LME/MCOs.
- (2) The Department shall award additional housing slots to LME/MCOs based on local need, as determined by the information provided on a monthly basis by LME/MCOs to the Department in accordance with G.S. 122C-20.9.

"§ 122C-20.11. Transition of program participants into housing slots.

The LME/MCO shall develop a written transition plan for each individual determined to be eligible and interested in participating in the North Carolina Supportive Housing Program. The transition plan shall identify at least all of the following:

- (1) Available housing slots that meet the individual's needs.
- (2) Any transition services that will be necessary for the individual, including, but not limited to, a one-time transition stability payment, not to exceed two thousand dollars (\$2,000) per individual, for up-front move-in costs approved by the Department or the housing subsidy administrator.
- (3) Solutions to potential barriers to the individual's successful transition to community-based supported housing.
- (4) The individual's assistive technology needs, as determined by an assessment conducted in accordance with G.S. 168-18.3.
- (5) Any other information the Department deems necessary for the individual program participant's successful transition into community-based supported housing.

"§ 122C-20.12. Transition services.

LME/MCOs shall provide individualized transition services to program participants within their respective catchment areas for the 90-day period following the individual's transition into a housing slot provided through the program.

"§ 122C-20.13. Tenancy support services.

The Department or the housing subsidy administrator shall provide ongoing tenancy support services to program participants.

"§ 122C-20.14. Approval of landlords and housing units.

The Department shall develop an application process for owners of housing units seeking to participate in the program as landlords. The application process shall, at a minimum, include an inspection of the owners' available housing units and a requirement that owners complete training on the North Carolina Supportive Housing Program prior to being approved as landlords.

"§ 122C-20.15. Rules to implement NC Supportive Housing Program.

The Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services may adopt any temporary rules necessary to implement this section.

"§ 122C-20.16. Annual reporting on NC Supportive Housing Program.

(a) Annually, on April 1, each LME/MCO shall report to the Department on the number of individuals within the catchment area who transitioned into housing slots available through the North Carolina Supportive Housing Program during the preceding calendar year. The report shall include a breakdown of all funds expended by the LME/MCO for transitioning these individuals into the housing slots.

(b) Annually, on July 1, the Department shall report to the General Assembly on the effectiveness of the North Carolina Supportive Housing Program established in this section.

"§ 122C-20.17. Department not obligated to provide unlimited number of housing slots.

Nothing in this section shall be construed to require the Department to provide housing slots to individuals beyond the number that can be supported by funds appropriated by the General Assembly for this purpose."

SECTION 2.(b) By no later than July 30, 2013, each LME/MCO shall transition at least 15 eligible individuals to community-based supported housing slots available through the North Carolina Supportive Housing Program established under G.S. 122C-20.5.

SECTION 2.(c) There is appropriated from the General Fund to the Transitions to Communing Living Housing Budget established in G.S. 122E-3A, the sum of three million eight hundred thirty-five thousand two hundred eighty dollars (\$3,835,280) for the 2013-2014 fiscal year and the sum of five million eight hundred seventy-six thousand dollars (\$5,876,000) for the 2014-2015 fiscal year. These funds shall be used as follows:

- (1) The sum of one million seven hundred forty-five thousand two hundred eighty dollars (\$1,745,280) for fiscal year 2013-2014 and the sum of three million one hundred twenty thousand thirty-seven dollars (\$3,120,037) for fiscal year 2014-2015 shall be used to establish and operate the North Carolina Supportive Housing Program authorized in G.S. 122C-20.5.
- (2) The sum of one million four hundred forty thousand dollars (\$1,440,000) for fiscal year 2013-2014 and the sum of one million five hundred forty thousand dollars (\$1,540,000) for fiscal year 2014-2015 shall be used for program administration for the North Carolina Supportive Housing Program authorized in G.S. 122C-20.5.
- (3) The sum of six hundred fifty thousand dollars (\$650,000) for fiscal year 2013-2014 and the sum of one million two hundred sixteen thousand dollars (\$1,216,000) for fiscal year 2014-2015 shall be used to provide one-time transition stability funds, not to exceed two thousand dollars (\$2,000) per individual, to cover the cost of up-front move-in costs for individuals placed in housing slots available through the North Carolina Supportive Housing Program authorized in G.S. 122C-20.5.

SECTION 3. Chapter 122E of the General Statutes is amended by adding a new section to read:

"§ 122E-3A. Transitions to Community Living Housing Budget.

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

- (1) Catchment area. – As defined in G.S. 122C-3.
- (2) Individuals with disabilities. – Individuals with severe mental illness, as defined in G.S. 122C-20.5, and severe and persistent mental illness, as defined in G.S. 122C-20.5.
- (3) Targeted units. – Units within Low Income Housing Tax Credit developments that are specifically designed to facilitate the inclusion of individuals with disabilities.
- (4) Transitions to Community Living Fund. – The Fund established in Section 10.23A.(d) of S.L. 2012-142.

(b) Creation and Source of Funds. – The Transitions to Community Living Housing Budget is established within the Transitions to Community Living Fund to pay for the transition of individuals with disabilities from institutional settings to integrated, community-based supported housing. Any unexpended, unencumbered balance of the amount appropriated in Section 10.23A(e) of S.L. 2012-142 at the end of each fiscal year, including the end of the 2012-2013 fiscal year, shall not revert and shall remain available in the Transitions to Community Living Housing Budget.

(c) Use of Funds. – The North Carolina Housing Finance Agency, in consultation with the Department of Health and Human Services, shall be responsible for administering the Transitions to Community Living Housing Budget. The funds in the Transitions to Community Living Housing Budget shall be available for expenditure only upon an act of appropriation by the General Assembly and only for the following purposes:

(1) To provide community-based supported housing in integrated settings appropriate for individuals with disabilities.

(2) To support housing projects in which the percentage of targeted units is at least fifteen percent (15%). Priority for funding shall be given to targeted units located in catchment areas identified by the Department of Health and Human Services, in consultation with the North Carolina Housing Finance Agency and LME/MCOs, as having the greatest need for targeted units.

(d) Sunset. – The Transitions to Community Living Fund terminates on June 30, 2020, and any balance remaining on that date shall revert to the General Fund."

SECTION 4.(a) Chapter 168 of the General Statutes is amended by adding a new Article to read:

"Article 2A.

"Assistive Technology for Individuals Transitioning Into Community Living.

"§ 168-18. Definitions.

The following definitions apply in this Article:

(1) Assistive technology device or ATD. – Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capacities of individuals with disabilities. This term includes durable medical equipment.

(2) Assistive technology services. – A device, service, strategy, or practice used to increase or improve functional capabilities of individuals with disabilities.

(3) Department. – North Carolina Department of Health and Human Services.

(4) Durable medical equipment or DME. – Equipment that meets all of the following criteria:

a. Can withstand repeated use.

b. Is primarily and customarily used to serve a medical purpose.

c. Generally is not useful to a person in the absence of an illness or injury.

d. Is appropriate for use in the home.

(5) Individuals with disabilities. – Individuals with severe mental illness, as defined in G.S. 122C-20.5, severe and persistent mental illness, as defined in G.S. 122C-20.5, or intellectual or developmental disabilities who are transitioning from institutional settings to integrated, community-based settings.

(6) Professional assistive technology consultant. – An individual who is certified as an assistive technology practitioner by an accrediting body approved by the Secretary or an individual who is employed by the Department as an assistive technology consultant.

(7) Secretary. – Secretary of the North Carolina Department of Health and Human Services.

"§ 168-18.1. Department to establish assistive technology reutilization program for individuals with disabilities transitioning into integrated, community-based settings.

The Department shall expand the North Carolina Assistive Technology Program to include an assistive technology reutilization program. The purpose of the assistive technology reutilization program is for the Department to (i) retrieve ATDs purchased with State funds,

1 including durable medical equipment purchased through the State Medicaid Program, from
2 consumers who no longer utilize the ATDs and (ii) catalogue, refurbish, sanitize, store, and
3 reassign the ATDs to individuals with disabilities.

4 **"§ 168-18.2. Preference for the assistive technology reutilization program.**

5 Prior to purchasing a new ATD for an individual with a disability, each Division within the
6 Department and each LME/MCO shall determine if a suitable refurbished ATD is available
7 through the assistive technology reutilization program authorized in G.S. 168-18. If available,
8 the Division or LME/MCO shall provide the refurbished ATD to the individual in lieu of
9 purchasing, or facilitating the purchase of, a new ATD; provided, however, the Division or an
10 LME/MCO may purchase a new ATD for an individual with a disability if the cost of
11 transporting the refurbished ATD to the individual would outweigh the cost of purchasing a
12 new ATD. The Division or LME/MCO shall provide each recipient of a new or refurbished
13 ATD with information about the assistive technology reutilization program.

14 **"§ 168-18.3. Outreach and training on assistive technology.**

15 The Department and LME/MCOs shall provide or arrange for outreach and training on
16 assistive technology devices for individuals with disabilities and professionals working with
17 these individuals. This outreach and training shall be conducted by individuals who are
18 knowledgeable about assistive technology and local community services and supports and
19 shall, at a minimum, include general information about the assistive technology reutilization
20 program, ATDs, how to include ATDs in the transition planning process, and various statewide
21 resources for accessing assistive technology services, ATD demonstrations, and ATD loans.

22 **"§ 168-18.4. Assessment of assistive technology needs.**

23 The Department or an LME/MCO, as appropriate, shall arrange for each individual with a
24 disability within its catchment area to undergo at least two assistive technology assessments by
25 a professional assistive technology consultant, one during the planning phase of the individual's
26 transition to an integrated, community-based setting and a second upon the individual's
27 transition into that setting. The assistive technology assessment conducted during the transition
28 planning phase shall be included in the individual's transition plan developed in accordance
29 with G.S. 122C-20.11. The purpose of the assistive technology assessment is to determine the
30 individual's specific assistive technology needs based on functional ability, environment, the
31 tasks to be completed with the assistive technology, and available technology options. The
32 assistive technology assessment shall cover the individual's home, independent living
33 environment, employment setting, or all three, as needed.

34 **"§ 168-18.5. Assistive technology device demonstrations and loans.**

35 The Department or an LME/MCO, as appropriate, shall arrange for individuals with
36 disabilities to access ATDs through the North Carolina Assistive Technology Program for trial
37 and demonstration during the planning phase of the individual's transition into an integrated,
38 community-based setting. The purpose of the trial and demonstration is to ensure that the
39 selected ATDs are the best match for the individual considering the individual's functional
40 ability, the environment, and the tasks to be completed with the assistive technology.
41 LME/MCOs may fulfill the requirements of this section by providing hands-on, online, or
42 remote demonstrations of ATDs, or by arranging for loans of ATDs to individuals with
43 disabilities during the planning phase of the individual's transition.

44 **"§ 168-18.6. Disposal of assistive technology devices and durable medical equipment.**

45 The Department shall transfer to the Department of Administration donations of assistive
46 technology devices that are deemed unfit for reuse or reassignment under the assistive
47 technology reutilization program. The Department of Administration shall dispose of these
48 donations as State surplus property."

49 **SECTION 4.(b)** There is appropriated from the General Fund to the Transitions to
50 Communing Living Housing Budget established in G.S. 122E-3A, the sum of two hundred
51 thousand dollars (\$200,000) for the 2013-2014 fiscal year and the sum of one hundred fifty

1 thousand dollars (\$150,000) for the 2014-2015 fiscal year. These funds shall be used to pay for
2 assistive technology assessments for individuals with disabilities who are transitioning from
3 institutional settings to integrated, based settings in order to identify the assistive technology
4 devices that are the best match for the individual considering the environment, task, and ability
5 of the user.

6 **SECTION 5.** Sections 2(c) and 4(b) of this act become effective July 1, 2013. The
7 remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S

D

SENATE BILL 663
PROPOSED COMMITTEE SUBSTITUTE S663-CSMG-18 [v.6]
5/28/2013 11:45:08 PM

Short Title: Blue Ribbon Comm. Recs./Supportive MH Housing.

(Public)

Sponsors:

Referred to:

April 4, 2013

A BILL TO BE ENTITLED
AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
ESTABLISH A SUPPORTIVE HOUSING PROGRAM AND AN ASSISTIVE
TECHNOLOGY REUTILIZATION PROGRAM FOR INDIVIDUALS TRANSITIONING
FROM INSTITUTIONAL SETTINGS TO INTEGRATED COMMUNITY-BASED
SETTINGS, TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES FOR THE ESTABLISHMENT AND OPERATION OF THESE
PROGRAMS, AND (3) TO CREATE COMMUNITY LIVING HOUSING FUND
WITHIN THE HOUSING FINANCE AGENCY TO INTEGRATE INDIVIDUALS WITH
DISABILITIES INTO COMMUNITY-BASED SUPPORTED HOUSING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO"
means a local management entity that is under contract with the Department
to operate the combined Medicaid Waiver program authorized under Section
1915(b) and Section 1915(c) of the Social Security Act."

SECTION 2.(a) Chapter 122C of the General Statutes is amended by adding a new

Article to read:

"Article 1B.

"Transitions to Community Living.

"Part 1. North Carolina Supportive Housing Program.

"§ 122C-20.5. Definitions.

The following definitions apply in this Article:

(1) In-reach activities. – Education and information provided by the Department
or an LME/MCO by individuals who are knowledgeable about community
services and supports to residents of adult care homes or State psychiatric
hospitals about the benefits and financial aspects of clinically appropriate,
community-based supportive housing in an integrated setting. The term
includes all of the following: (i) facilitating and accompanying residents'
visits to supportive housing apartments, (ii) assessing residents' interest in
supportive housing, (iii) exploring and addressing residents' concerns about
moving to supportive housing, (iv) reviewing residents' housing preferences,
and (v) providing opportunities for residents to meet with other individuals
with disabilities who are living, working, and receiving services in integrated
settings; their families; and community providers. This term does not include
education or information provided by adult care homes.



* S 6 6 3 - C S M G - 1 8 - V - 6 *

(2) Individual with serious mental illness or SMI. – An individual who is 18 years of age or older with a mental illness or disorder that is described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, that impairs or impedes functioning in one or more major areas of living and is unlikely to improve without treatment, services, supports, or all three. The term does not include a primary diagnosis of Alzheimer's disease or dementia.

(3) Individual with serious and persistent mental illness or SPMI. – A person who is 18 years of age or older who meets one of the following criteria:

a. Has a mental illness or disorder that is so severe and chronic that it prevents or erodes development of functional capacities in primary aspects of daily life such as personal hygiene and self-care, decision making, interpersonal relationships, social transactions, learning, and recreational activities.

b. Is receiving Supplemental Security Income or Social Security Disability Income due to mental illness.

"§ 122C-20.6. Department to establish statewide supportive housing program for individuals transitioning into community living; purpose.

The Department of Health and Human Services, in consultation with the North Carolina Housing Finance Agency, shall establish and administer a tenant-based rental assistance program known as the North Carolina Supportive Housing Program. The purpose of the program is to transition individuals diagnosed with serious mental illness or serious and persistent mental illness from institutional settings to more integrated community-based settings appropriate to meet their needs. Under the program, the Department, in consultation with the North Carolina Housing Finance Agency and LME/MCOs, shall arrange for program participants to be placed in housing slots available through the program with all the rights and obligations created by a landlord-tenant relationship.

"§ 122C-20.7. Administration of housing subsidies for supportive housing.

The Department may enter into a contract with a private vendor to serve as the housing subsidy administrator for the North Carolina Supportive Housing Program with responsibility for distributing rental vouchers and community living vouchers to program participants based on a formula developed by the Department.

"§ 122C-20.8. Eligibility requirements for NC Supportive Housing Program.

The Division of Aging and Adult Services shall adopt rules to establish eligibility requirements for program. The eligibility requirements shall, at a minimum, include income eligibility requirements and requirements to give priority for program participation and transition services to individuals diagnosed with serious mental illness or serious and persistent who are currently residing in institutional settings. The Division may adopt temporary rules necessary to implement this article.

"§ 122C-20.9. In-reach activities for supportive housing.

The Department shall have ongoing responsibility for developing and distributing a list of potentially eligible program participants for each LME/MCO by catchment area. Upon receipt of this information, each LME/MCO shall have ongoing responsibility for prioritizing the list of individuals to whom it will provide in-reach activities in order to (i) arrange an in-person meeting with potentially eligible participants to determine their eligibility and level of interest and (ii) report back to the Department on the LME/MCO's recommended list of program participants on a daily basis. Upon receipt of an LME/MCO's recommended list of program participants, the Department shall make a final determination of eligibility.

"§ 122C-20.10. Allocation of supportive housing slots to LME/MCOs.

The Department shall annually determine the number of housing slots to be allocated to each LME/MCO as follows:

- (1) Each year, the Department shall distribute at least fifty percent (50%) of the housing slots available through this program equally among all LME/MCOs.
- (2) The Department shall award additional housing slots to LME/MCOs based on local need, as determined by the information provided by LME/MCOs to the Department in accordance with G.S. 122C-20.9.

"§ 122C-20.11. Transition of program participants into housing slots.

The LME/MCO shall develop a written transition plan for each individual determined to be eligible and interested in participating in the North Carolina Supportive Housing Program. The transition plan for the approved housing slot shall identify at least all of the following:

- (1) Available housing units that meet the individual's needs.
- (2) Any transition services that will be necessary for the individual, including, but not limited to, a one-time transition stability payment, not to exceed two thousand dollars (\$2,000) per individual, for up-front move-in costs approved by the Department or the housing subsidy administrator.
- (3) Solutions to potential barriers to the individual's successful transition to community-based supported housing.
- (4) The individual's assistive technology needs, as determined by an assessment conducted in accordance with G.S. 168-18.3.
- (5) Any other information the Department deems necessary for the individual program participant's successful transition into community-based supported housing.

"§ 122C-20.12. Transition services.

LME/MCOs shall provide individualized transition services to program participants within their respective catchment areas for the 90-day period following the individual's transition into a housing slot provided through the program.

"§ 122C-20.13. Tenancy support services.

The Department or the housing subsidy administrator shall provide ongoing tenancy support services to program participants.

"§ 122C-20.14. Approval of landlords and housing units.

The Department shall develop an application process for owners of housing units seeking to participate in the program as landlords. The application process shall, at a minimum, include an inspection of the owners' selected housing units and a requirement that owners receive educational information from the Department about the North Carolina Supportive Housing Program prior to being approved as landlords.

"§ 122C-20.15. Annual reporting on NC Supportive Housing Program.

Annually on October 1, the Department shall report to the General Assembly on the number of individuals within each catchment area who transitioned into housing slots available through the North Carolina Supportive Housing Program during the preceding calendar year. The report shall include a breakdown of all funds expended by each LME/MCO for transitioning these individuals into the housing slots.

"§ 122C-20.16. NC Supportive Housing Program not an entitlement.

The Department shall not be required to provide housing slots to individuals beyond the number that can be supported by funds appropriated by the General Assembly for this purpose. The supportive housing program established under this Part, whether administered by the Department or a private entity, is not an entitlement, and nothing in this Part shall create any property right.

SECTION 2.(b) By no later than June 30, 2013, each LME/MCO shall transition at least 15 eligible individuals to community-based supported housing slots available through the North Carolina Supportive Housing Program established under G.S. 122C-20.5.

SECTION 3. There is appropriated from the General Fund to the Department of Health and Human Services, the sum of three million eight hundred thirty-five thousand two

hundred eighty dollars (\$3,835,280) for the 2013-2014 fiscal year and the sum of five million eight hundred seventy-six thousand dollars (\$5,876,000) for the 2014-2015 fiscal year. These funds shall be used as follows:

- (1) The sum of one million seven hundred forty-five thousand two hundred eighty dollars (\$1,745,280) for fiscal year 2013-2014 and the sum of three million one hundred twenty thousand thirty-seven dollars (\$3,120,037) for fiscal year 2014-2015 shall be used to establish and operate the North Carolina Supportive Housing Program authorized in G.S. 122C-20.5.
- (2) The sum of one million four hundred forty thousand dollars (\$1,440,000) for fiscal year 2013-2014 and the sum of one million five hundred forty thousand dollars (\$1,540,000) for fiscal year 2014-2015 shall be used for program administration for the North Carolina Supportive Housing Program authorized in G.S. 122C-20.5.
- (3) The sum of six hundred fifty thousand dollars (\$650,000) for fiscal year 2013-2014 and the sum of one million two hundred sixteen thousand dollars (\$1,216,000) for fiscal year 2014-2015 shall be used to provide one-time transition stability funds, not to exceed two thousand dollars (\$2,000) per individual, to cover the cost of up-front move-in costs for individuals placed in housing slots available through the North Carolina Supportive Housing Program authorized in G.S. 122C-20.5.

SECTION 4. Chapter 122E of the General Statutes is amended by adding a new section to read:

"§ 122E-3A. Community Living Housing Fund.

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

- (1) Catchment area. – As defined in G.S. 122C-3.
- (2) Targeted units. – Units within Low Income Housing Tax Credit developments that are specifically designed to facilitate the inclusion of individuals with disabilities.

(b) Creation and Source of Funds. – The Community Living Housing Fund is established within the Housing Finance Agency to pay for the transition of individuals diagnosed with severe mental illness or severe and persistent mental illness as defined in 122C-20.5 from institutional settings to integrated, community-based supported housing and to increase the percentage of targeted housing units available to individuals with disabilities for use in the North Carolina Supportive Housing Program under Article 1B of Chapter 122C. Beginning with fiscal year 2013-2014, any unexpended, unencumbered balance of the amount appropriated to the Transitions to Community Living Fund pursuant to Section 10.23A of S.L. 2012 at the end of each fiscal year shall not revert but shall be transferred and made available to the Community Living Housing Fund.

(c) Use of Funds. – The North Carolina Housing Finance Agency, in consultation with the Department of Health and Human Services, shall be responsible for administering the Community Living Housing Fund. The monies in the Fund shall be available for expenditure only upon an act of appropriation by the General Assembly and only for the following purposes:

- (1) To provide permanent community-based housing in integrated settings appropriate for individuals with severe mental illness and severe and persistent mental illness.
- (2) To support an increase in the number of targeted units for individuals with disabilities located in housing projects funded by the Housing Finance Agency from ten percent (10%) to fifteen percent (15%). The additional targeted units funded shall be made available to the Department of Health and Human Services for use in the North Carolina Supportive Housing

Program under Article 1B of Chapter 122C. Priority for funding of the additional targeted units shall be given to units to be located in catchment areas identified by the Department of Health and Human Services, in consultation with the North Carolina Housing Finance Agency and LME/MCOs, as having the greatest need for targeted units.

(d) Sunset. – The Transitions to Community Living Fund terminates on June 30, 2020, and any balance remaining on that date shall revert to the General Fund.

SECTION 5.(a) Chapter 168 of the General Statutes is amended by adding a new Article to read:

"Article 2A.

"Assistive Technology for Individuals Transitioning Into Community Living.

"§ 168-18. Definitions.

The following definitions apply in this Article:

- (1) Assistive technology device or ATD. – Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capacities of individuals with disabilities. This term includes durable medical equipment.
- (2) Assistive technology services. – A device, service, strategy, or practice used to increase or improve functional capabilities of individuals with disabilities.
- (3) Department. – North Carolina Department of Health and Human Services.
- (4) Durable medical equipment or DME. – Equipment that meets all of the following criteria:
 - a. Can withstand repeated use.
 - b. Is primarily and customarily used to serve a medical purpose.
 - c. Generally is not useful to a person in the absence of an illness or injury.
 - d. Is appropriate for use in the home.
- (5) Individuals with disabilities. – Individuals with serious mental illness, as defined in G.S. 122C-20.5, or serious and persistent mental illness, as defined in G.S. 122C-20.5, who are transitioning from institutional settings to integrated, community-based settings.
- (6) Professional assistive technology consultant. – An individual who is certified as an assistive technology practitioner by an accrediting body approved by the Secretary or an individual who is employed by the Department as an assistive technology consultant.
- (7) Secretary. – Secretary of the North Carolina Department of Health and Human Services.

"§ 168-18.1. Department to establish assistive technology reutilization program for individuals with disabilities transitioning into integrated, community-based settings.

The Department shall expand the North Carolina Assistive Technology Program to include an assistive technology reutilization program. The purpose of the assistive technology reutilization program is for the Department to (i) retrieve ATDs purchased with State funds, including durable medical equipment purchased through the State Medicaid Program, from consumers who no longer utilize the ATDs and (ii) catalogue, refurbish, sanitize, store, and reassign the ATDs to individuals with disabilities.

"§ 168-18.2. Preference for the assistive technology reutilization program.

Prior to purchasing a new ATD for an individual with a disability, each Division within the Department and each LME/MCO shall determine if a suitable refurbished ATD is available through the assistive technology reutilization program authorized in G.S. 168-18. If available, the Division or LME/MCO shall provide the refurbished ATD to the individual in lieu of

1 purchasing, or facilitating the purchase of, a new ATD; provided, however, the Division or an
2 LME/MCO may purchase a new ATD for an individual with a disability if the cost of
3 transporting the refurbished ATD to the individual would outweigh the cost of purchasing a
4 new ATD. The Division or LME/MCO shall provide each recipient of a new or refurbished
5 ATD with information about the assistive technology reutilization program.

6 **"§ 168-18.3. Outreach and training on assistive technology.**

7 The Department and LME/MCOs shall provide or arrange for outreach and training on
8 assistive technology devices for individuals with disabilities and professionals working with
9 these individuals. This outreach and training shall be conducted by individuals who are
10 knowledgeable about assistive technology and local community services and supports and
11 shall, at a minimum, include general information about the assistive technology reutilization
12 program, ATDs, how to include ATDs in the transition planning process, and various statewide
13 resources for accessing assistive technology services, ATD demonstrations, and ATD loans.

14 **"§ 168-18.4. Assessment of assistive technology needs.**

15 The Department or an LME/MCO, as appropriate, shall arrange for each individual with a
16 disability within its catchment area to undergo at least two assistive technology assessments by
17 a professional assistive technology consultant, one during the planning phase of the individual's
18 transition to an integrated, community-based setting and a second upon the individual's
19 transition into that setting. The assistive technology assessment conducted during the transition
20 planning phase shall be included in the individual's transition plan developed in accordance
21 with G.S. 122C-20.11. The purpose of the assistive technology assessment is to determine the
22 individual's specific assistive technology needs based on functional ability, environment, the
23 tasks to be completed with the assistive technology, and available technology options. The
24 assistive technology assessment shall cover the individual's home, independent living
25 environment, employment setting, or all three, as needed.

26 **"§ 168-18.5. Assistive technology device demonstrations and loans.**

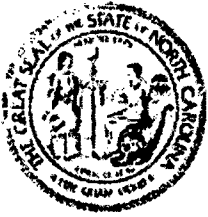
27 The Department or an LME/MCO, as appropriate, shall arrange for individuals with
28 disabilities to access ATDs through the North Carolina Assistive Technology Program for trial
29 and demonstration during the planning phase of the individual's transition into an integrated,
30 community-based setting. The purpose of the trial and demonstration is to ensure that the
31 selected ATDs are the best match for the individual considering the individual's functional
32 ability, the environment, and the tasks to be completed with the assistive technology.
33 LME/MCOs may fulfill the requirements of this section by providing hands-on, online, or
34 remote demonstrations of ATDs, or by arranging for loans of ATDs to individuals with
35 disabilities during the planning phase of the individual's transition.

36 **"§ 168-18.6. Disposal of assistive technology devices and durable medical equipment.**

37 The Department shall transfer to the Department of Administration donations of assistive
38 technology devices that are deemed unfit for reuse or reassignment under the assistive
39 technology reutilization program. The Department of Administration shall dispose of these
40 donations as State surplus property."

41 **SECTION 5.(b)** There is appropriated from the General Fund to the Transitions to
42 Community Living Fund established pursuant to Section 10.23A.(d) of S.L. 2012, the sum of
43 one hundred fifty thousand dollars (\$150,000) for the 2014-2015 fiscal year. These funds shall
44 be used to pay for assistive technology assessments and assistive technology devices for
45 individuals with disabilities who are transitioning from institutional settings to integrated, based
46 settings in order to identify the assistive technology devices that are the best match for the
47 individual considering the environment, task, and ability of the user.

48 **SECTION 6.** Section 3 of this act becomes effective July 1, 2014, Section 5(b) of
49 this act become effective July 1, 2013. The remainder of this act is effective when it becomes
50 law.



SENATE BILL 663: Blue Ribbon Comm. Recs./Supportive MH Housing

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	Date:	May 28, 2013
Introduced by:	Sen. Hise	Prepared by:	Barbara Riley
Analysis of:	PCS to First Edition S663-CSMG-18		Committee Counsel

SUMMARY: *Senate Bill 663 establishes a tenant based rental assistance program to be known as the NC Supportive Housing Program to help transition persons with serious mental illness (SMI) and serious and persistent mental illness (SPMI) from institutional settings to more integrated community based living as appropriate for their needs and appropriates funds to implement the program. The bill also establishes a Community Living Housing Fund within the Housing Finance Agency to be used to provide permanent community based housing to individuals diagnosed with SMI and SPMI and to increase the number of targeted units available for individuals with disabilities and make them available to the Supportive Housing Program. The bill also creates a new Article 2A in Chapter 168 of the General Statutes that establishes an assistive technology reutilization program, provides for assistive technology assessments prior to an individual's transition to a community setting, and requires DHHS or the LME/MCO to arrange for individuals to access assistive technology devices for trial and evaluation during the planning phase of the transition.*

The First Edition of S663 was a recommendation of the Housing Subcommittee of the Blue Ribbon Commission on Transitions to Community Living.

BILL ANALYSIS: Section 1 adds a definition of "Local management entity/managed care organization to G.S. 122C-3.

Section 2.(a) of the bill adds Article 1B to Chapter 122 and creates the North Carolina Supportive Housing Program.

G.S. 122C-20.5 provides definitions for the new Article. "In reach activities" include education and information provided by DHHS and the LME/MCO's about the benefits and financial aspects of clinically appropriate community-based supported housing. The term includes facilitating and accompanying individuals to view supported housing units, assessing interest and exploring concerns about moving to supported housing, reviewing housing preferences and providing opportunities to meet with individuals who are living, working, and receiving services in integrated settings. It does not include information provided by adult care homes. Individuals with "serious mental illness (SMI)" are those who have been diagnosed with a mental illness or disorder that impairs or impedes functioning in one or more major areas of living and who are not likely to improve without treatment, supports, or services. It does not include persons with Alzheimer's disease or dementia. Individuals with "serious and persistent mental illness (SPMI)" are 18 or older, have a mental illness so severe and chronic that it prevents or erodes functional capacities in primary aspects of daily life, and who are receiving SSI or Social Security Disability Income due to mental illness.

G.S. 122C-20.6 directs DHHS, in consultation with the NC Housing Finance Agency to establish and administer a tenant based rental program. The purpose of the program is to transition persons diagnosed with SMI or SPMI out of institutional settings to more integrated community based settings. The

O. Walker Reagan
Director



Research Division
(919) 733-2578

* S 6 6 3 - S M R F - 3 9 C S M G - 1 8 - V 2 *

Senate PCS 663

Page 2

program shall provide for individuals to be placed in housing slots available through the program with all the rights and obligations of a landlord-tenant relationship.

G.S. 122C-20.7 authorizes DHHS to contract with a private vendor to serve as the housing subsidy administrator and to distribute rental vouchers and community living vouchers to program participants based on DHHS developed formulas.

G.S. 122C-20.8 directs the Division of Aging and Adult Services to adopt rules on the eligibility requirements for the program, including income eligibility and priority for individuals with SMI/SPMI who live in institutional settings.

G.S. 122C-20.9 provides DHHS with ongoing responsibility to develop and distribute a list of potentially eligible individuals for the program for each LME/MCO. The LME/MCO must prioritize the list and arrange for in person meetings with potentially eligible participants to determine their level or interest. The LME/MCO's must report back to DHHS on the LME/MCO's recommended list of program participants on a daily basis. Upon receipt of the report DHHS shall make the final determination on eligibility.

G.S. 122C-20.10 provides for DHHS to annually determine the number of housing slots to be allocated. Each year 50% of the slots available will be equally distributed among all LME/MCO's. Additional slots will be allocated based on local need as determined by information submitted by the LME/MCO's.

G.S. 122C-20.11 requires LME/MCO's to develop individual, written transition plans that include (1) available housing units that meet the individual's needs; (2) necessary transition services including a one-time stability payment up to \$2,000 for up front move in costs; (3) solutions to potential barriers to successful transition; (4) the individual's assistive technology needs; and (5) other information DHHS deems necessary for successful transition.

G.S. 122C-20.12 directs LME/MCO's to provide individualized transition services to program participants for the first 90 days after the transition to a housing slot.

G.S. 122C-20.13 directs DHHS or the housing subsidy administrator to provide ongoing tenancy support services.

G.S. 122C-20.14 directs DHHS to develop an application process for landlords seeking to participate in the program. The process will include an inspection of the selected housing units and require that the landlord receive educational information about the program before being approved.

G.S. 122C-15 requires annual reports by DHHS to the General Assembly on the number of individuals in each catchment area who transitioned into housing slots through the program in the previous year including a breakdown of funds expended by the LME/MCO's to transition the individuals.

G.S. 122C-16 establishes that the program is not an entitlement. DHHS is not required to provide housing slots beyond the number that can be supported by appropriations by the General Assembly for that purpose.

Section 2.(b) requires each LME/MCO to transition at least 15 eligible individuals to community based housing slots by June 30, 2013.

Section 3 of the bill appropriates \$3,835,280 for FY 2013-2014 and \$5,876,000 for FY 2014-2015 to DHHS to be used as follows:

- \$1,745,280 for FY 2013-2014 and \$3,120,037 for FY 2014-2015 to establish and operate the NC Supportive Housing Program.
- \$1,440,000 for FY 2013-2014 and \$1,540,000 for FY 2014-2015 for program administration.

Senate PCS 663

Page 3

- \$650,000 for FY 2013-2014 and \$1,216,000 for FY 2014-2015 to provide one-time transition stability funds (not to exceed \$2,000 per individual).

Section 4 establishes a Community Living Housing Fund within the Housing Finance Authority. The Fund will consist of unexpended and unencumbered money appropriated to the Transitions to Community Living Fund beginning in FY 2013-2014. The Fund shall be used, only on appropriation by the General Assembly, to (1) provide permanent community based housing for individuals with SMI or SPMI and (2) support an increase in the number of targeted units for individuals with disabilities located in housing projects funded by the Housing Finance Agency from 10% to 15%. The additional targeted units will be made available to DHHS for the Supportive Housing Program.

Section 5.(a) creates a new Article 2A in Chapter 168 "Assistive Technology for Individuals Transitioning into Community Living".

G.S. 168-18 defines an "assistive technology device" (ATD) as an item, equipment, or product system used to increase, maintain, or improve the functional capacity of individuals with disabilities. "Assistive technology services" are devices, strategies, or services that increase or improve functional capabilities. "Individuals with disabilities" are defined as those diagnosed with SMI or SPMI who are transitioning to community based supportive housing.

G.S. 168-18.1 direct DHHS to expand the NC Assistive Technology Program to include a reutilization program. DHHS is to retrieve ATD's and durable medical equipment purchased with State funds that are no longer being used and catalogue, refurbish, sanitize, store and reassign the ATD's.

G.S. 168-18.2 directs each division within DHHS and each LME/MCO to determine if refurbished ATD's are available in lieu of new purchases. If transportation costs of an ATD would outweigh the cost of a new purchase, then a new ATD may be purchased and provided to the individual.

G.S. 168-18.3 directs DHHS and the LME/MCO's to provide or arrange for outreach and training on ATD's for individuals with disabilities and professionals working with them.

G.S. 168-18.4 requires professional assisted technology assessments for individuals transitioning to community based supportive housing; one during the planning phase of the transition and a second upon the transition into the new setting. The assessment shall cover the individual's home, independent living environment, and employment setting. The first assessment shall be incorporated into the individual's transition plan pursuant to G.S. 122C-20.11.

G.S. 168-18.5 provides for DHHS or the LME/MCO to arrange for individuals to access ATD's through the NC Assistive Technology Program for trial and demonstration during the planning phase of the transition.

G.S. 168-18.6 directs DHHS to transfer donated ATD's unfit for reuse to the Department of Administration for disposal as surplus property.

Section 5.(b) appropriates \$150,000 for FY 2014-2015 to the Transitions for Community Living Fund to pay for assisted technology assessments and ATD's for individuals with disabilities.

EFFECTIVE DATE: Sections 3 becomes effective July 1, 2014. Section 5.(b) becomes effective July 1, 2013. The remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

1

HOUSE BILL 492

Short Title: Tier II Medicaid PCS for Alzheimers/Dementia.

(Public)

Sponsors: Representative Dollar (Primary Sponsor).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Health and Human Services, if favorable; Appropriations.

April 2, 2013

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP TIER II – ENHANCED MEDICAID PERSONAL CARE SERVICES FOR INDIVIDUALS WITH A PRIMARY DIAGNOSIS OF ALZHEIMER'S OR OTHER SPECIFIED FORMS OF DEMENTIA AND TO REPORT TO THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES, THE SENATE APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES, AND TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Sections 10.9F(c) and (d) of S.L. 2012-142, as amended by Section 70 of S.L. 2012-194, read as rewritten:

"SECTION 10.9F.(c) Eligibility for Tier I – Medicaid Personal Care Services – A Medicaid recipient who meets each of the following criteria is eligible for Tier I personal care services:

- (1) The recipient has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum, (i) three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance; (ii) two ADLs, one of which requires extensive assistance; or (iii) two ADLs, one of which requires assistance at the full dependence level.
- (2) The recipient (i) resides in a private living arrangement, a residential facility licensed by the State of North Carolina as an adult care home, or a combination home as defined in G.S. 131E-101(1a); or (ii) resides in a group home licensed under Chapter 122C or the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency, and is eligible to receive personal care services under the Medicaid State Plan.

The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility. For Medicaid recipients meeting the criteria above, Personal-Tier I personal care services shall be available for up to 80 hours per month in accordance with an assessment conducted under subsection (d) of this section and a plan of care developed by the service provider and approved by the Department of Health and Human Services, Division of Medical Assistance, or its designee.



* H 4 9 2 - V - 1 *

1 Eligibility for Tier II – Enhanced Medicaid Personal Care Services – A Medicaid recipient
2 is eligible for Tier II – Enhanced Personal Care Services if the individual meets the eligibility
3 criteria for Tier I – Medicaid Personal Care Services provided in subdivisions (1) and (2) of this
4 subsection, in addition to the requirements listed below.

5 (3) The recipient's physician attests that the recipient has a primary diagnosis of
6 one of the following: Alzheimer's Disease, Vascular Dementia, Dementia
7 with Lewy Bodies, Pick's Disease, Parkinson's Disease, Creutzfeldt-Jakob
8 Disease, or Huntington's Disease. A recipient may also meet this
9 requirement with an attestation that the recipient has dementia-undetermined
10 as long as this diagnosis is made and documented by a neurologist.

11 a. A recipient is not required to have a new attestation if they are
12 identified by the Department of Health and Human Services,
13 Division of Medical Assistance as having on record a physician's
14 attestation of a primary diagnosis that meets the requirements of this
15 subdivision.

16 b. A recipient is required to have a new attestation if one cannot be
17 identified by the Division of Medical Assistance or if the one
18 identified does not meet the requirements of this subdivision.

19 (4) Based on the physician's attestation in subdivision (3) of this subsection, the
20 Medicaid recipient must receive an independent assessment conducted by a
21 trained professional who is qualified to assess and has experience assessing
22 the personal care services needs of individuals with the primary diagnoses
23 outlined in subdivision (3) of this subsection. The independent assessment
24 shall be conducted in accordance with subsection (d) of this section and shall
25 determine the number of hours of personal care services needed by the
26 individual. In response to the assessment, a plan of care shall be developed
27 by the service provider and approved by the Department of Health and
28 Human Services, Division of Medical Assistance, or its designee.

29 In accordance with an assessment and a plan of care, Medicaid recipients meeting all of the
30 eligibility requirements for Tier II – Enhanced Medicaid Personal Care Services shall be
31 eligible for up to a total of 130 hours per month which includes the maximum hours allowed in
32 Tier I.

33 Personal care services shall not include nonmedical transportation; financial management;
34 non-hands-on assistance such as cueing, prompting, guiding, coaching, or babysitting; and
35 household chores not directly related to the qualifying ADLs.

36 "SECTION 10.9F.(d) All assessments for personal care services, continuation of service,
37 and change of status reviews shall be performed by an independent assessment entity (IAE).
38 The IAE shall not be an owner of a provider business or provider of personal care services of
39 any type.

40 A recipient shall be assessed by the IAE after the recipient's primary or attending physician
41 provides written authorization for referral for the service and written attestation to the medical
42 necessity for the service. A Medicaid recipient shall receive an assessment to determine
43 eligibility of Tier II – Enhanced Medicaid Personal Care Services if a physician attests to the
44 eligibility criteria required for Tier II services. The IAE shall determine and authorize the
45 amount of service to be provided as determined by its review and findings of each recipient's
46 degree of functional disability and level of unmet needs for personal care services in the five
47 qualifying ADLs."

48 SECTION 2. The Department of Health and Human Services shall implement Tier
49 II – Enhanced Medicaid Personal Care Services within available funds.

50 SECTION 3.(a) On or before May 1, 2013, the Department of Health and Human
51 Services shall make an interim report on the implementation of this act to the House

1 Appropriations Subcommittee on Health and Human Services and to the Senate Appropriations
2 Committee on Health and Human Services. The report shall include the following: (i) an
3 estimate of the number of Medicaid recipients that would be eligible for Tier II – Enhanced
4 Medicaid Personal Care Services; (ii) an estimate of the number of PCS hours potential Tier II
5 recipients would need broken out in increments of 10 hours between 80 and 130 hours, (iii) a
6 copy of the draft Medicaid State Plan Amendment (SPA), (iv) the estimated time line for
7 approval of the SPA and a projected implementation date, and (v) any rate reductions necessary
8 to implement this act.

9 **SECTION 3.(b)** On or before August 1, 2013, and on or before November 1, 2013,
10 the Department of Health and Human Services shall report on the implementation of this act to
11 the Joint Legislative Oversight Committee on Health and Human Services.

12 **SECTION 4.** Sections 1 and 2 of this act become effective July 1, 2013. The
13 remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

D

HOUSE BILL 492
Committee Substitute Favorable 4/24/13
Third Edition Engrossed 5/2/13
PROPOSED SENATE COMMITTEE SUBSTITUTE H492-CSSH-17 [v.4]
5/28/2013 7:04:33 PM

Short Title: Safeguard Qualified Individuals-Medicaid PCS.

(Public)

Sponsors:

Referred to:

April 2, 2013

A BILL TO BE ENTITLED
AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
ADJUST MEDICAID PERSONAL CARE SERVICES TO PROVIDE ADDITIONAL
SAFEGUARDS FOR QUALIFIED INDIVIDUALS AND TO REPORT TO THE HOUSE
APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES, THE
SENATE APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES,
AND TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND
HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Sections 10.9F(c) and (d) of S.L. 2012-142, as amended by Section
70 of S.L. 2012-194, read as rewritten:

"SECTION 10.9F.(c) A Medicaid recipient who meets each of the following criteria is
eligible for up to 80 hours of personal care services:

- (1) The recipient has a medical condition, disability, or cognitive impairment
and demonstrates unmet needs for, at a minimum, (i) three of the five
qualifying activities of daily living (ADLs) with limited hands-on assistance;
(ii) two ADLs, one of which requires extensive assistance; or (iii) two
ADLs, one of which requires assistance at the full dependence level.
- (2) The recipient (i) resides in a private living arrangement, a residential facility
licensed by the State of North Carolina as an adult care home, or a
combination home as defined in G.S. 131E-101(1a); or (ii) resides in a group
home licensed under Chapter 122C or the General ~~Statutes~~ Statutes and under
10A NCAC 27G .5601 as a supervised living facility for two or more adults
whose primary diagnosis is mental illness, a developmental disability, or
substance abuse dependency, and is eligible to receive personal care services
under the Medicaid State Plan.

The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility. For
Medicaid recipients meeting the criteria above, ~~Personal~~ personal care services shall be
available for up to 80 hours per month in accordance with an assessment conducted under
subsection (d) of this section and a plan of care developed by the service provider and approved
by the Department of Health and Human Services, Division of Medical Assistance, or its
designee.

- (3) A Medicaid recipient who meets the eligibility criteria provided in
subdivisions (1) and (2) of this subsection and all of the criteria provided



* H 4 9 2 - C S S H - 1 7 - V - 4 *

below is eligible for up to 50 additional hours of Medicaid Personal Care Services per month for a total of up to 130 hours per month in accordance with an assessment and a plan of care.

- a. The recipient requires an increased level of supervision.
- b. The recipient requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- c. Regardless of setting, the recipient requires a physical environment that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- d. The recipient exhibits safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Physician attestation. – A recipient must have a physician's attestation that the recipient meets each of the criteria in sub-subdivisions a. through d. of subdivision 3 of this subsection. A recipient is not required to have a new attestation if he or she is identified by the Department of Health and Human Services, Division of Medical Assistance, as having on record a physician's attestation that meets the requirements of this subdivision. A recipient is required to have a new attestation if one cannot be identified by the Division of Medical Assistance or if the one identified does not meet the requirements of this subdivision.

Independent assessment. – Based on the physician's attestation, the Medicaid recipient must receive an independent assessment conducted by a trained professional who is qualified to assess and has experience assessing individuals with the needs for additional safeguards identified by this subdivision. The independent assessment shall be conducted in accordance with subsection (d) of this section and shall determine the number of hours of personal care services needed by the individual. In response to the assessment, a plan of care shall be developed by the service provider and approved by the Department of Health and Human Services, Division of Medical Assistance, or its designee.

Personal care services shall not include nonmedical transportation; financial management; non-hands-on assistance such as cueing, prompting, guiding, coaching, or babysitting; and household chores not directly related to the qualifying ADLs.

"SECTION 10.9F.(d) All assessments for personal care services, continuation of service, and change of status reviews shall be performed by an independent assessment entity (IAE). The IAE shall not be an owner of a provider business or provider of personal care services of any type.

A recipient shall be assessed by the IAE after the recipient's primary or attending physician provides written authorization for referral for the service and written attestation to the medical necessity for the service. The IAE shall determine and authorize the amount of service to be provided as determined by its review and findings of each recipient's degree of functional disability and level of unmet needs for personal care services in the five qualifying ADLs."

SECTION 2. The Department of Health and Human Services shall reduce the rate for personal care services in order to fund the additional service hours authorized in Section 1

1 of this act and in order to remain within the budgeted amount of funds for personal care
2 services.

3 **SECTION 3.** On or before July 1, 2013, the Department of Health and Human
4 Services shall submit to the Centers for Medicare and Medicaid Services, a Medicaid State Plan
5 Amendment necessary to implement this act.

6 **SECTION 4.(a)** On or before August 1, 2013, the Department of Health and
7 Human Services shall make an interim report on the implementation of this act to the House
8 Appropriations Subcommittee on Health and Human Services, to the Senate Appropriations
9 Committee on Health and Human Services, and to the Fiscal Research Division. The report
10 shall include the following: (i) an estimate of the number of Medicaid recipients that would be
11 eligible for Medicaid Personal Care Services under this act, (ii) an estimate of the number of
12 PCS hours potential recipients would need broken out in increments of 10 hours between 80
13 and 130 hours, (iii) a copy of the draft Medicaid State Plan Amendment (SPA), (iv) an
14 estimated time line for approval of the SPA and a projected implementation date, and (v) the
15 rate reductions necessary to implement this act.

16 **SECTION 4.(b)** On or before November 1, 2013, the Department of Health and
17 Human Services shall report on the implementation of this act to the Joint Legislative Oversight
18 Committee on Health and Human Services.

19 **SECTION 5.** This act becomes effective July 1, 2013.



HOUSE BILL 492: Safeguard Qualified Individuals-Medicaid PCS

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	Date:	May 28, 2013
Introduced by:	Rep. Dollar	Prepared by:	Theresa Matula
Analysis of:	PCS to Third Edition H492-CSSH-17		Committee Staff

SUMMARY: *House Bill 492 establishes additional eligibility criteria for recipients of Medicaid Personal Care Services allowing those that meet the additional criteria to be eligible for up to 130 hours of Personal Care Services per month (the current maximum is 80 hours). The Proposed Committee Substitute directs the Department of Health and Human Services to apply for a Medicaid State Plan Amendment; to reduce the rate of Personal Care Services in order to fund the additional hours within budgeted amounts; and to make status reports.*

Senate Bill 402, v.3, the Senate Budget, contains Section 12H.14 providing Additional Personal Care Services for Qualified Individuals which is substantially similar to the PCS for HB 492.

BACKGROUND:

The North Carolina State Medicaid Plan provides for the receipt of Personal Care Services (PCS) by qualified Medicaid recipients. According to the State Plan, "[p]ersonal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility."

The federal Centers for Medicare and Medicaid Services (CMS) requires services to be comparable in all settings. To achieve this goal of comparability for the In-Home Care program and the Adult Care Home program, a new Consolidated PCS Program began effective January 1, 2013. (Session Law 2012-142, Section 10.F).

As of January 1, 2013, Medicaid recipients seeking authorization for Personal Care Services must receive an independent assessment. A Medicaid recipient is eligible for Personal Care Services if he or she has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum, one of the following criteria:

- Three of the five ADLs with limited hands-on assistance.
- Two ADLs, one of which requires extensive assistance.
- Two ADLs, one of which requires assistance at the full dependence level.

Medicaid recipients meeting the above criteria are eligible for up to 80 hours per month of PCS, in accordance with the individual's needs determined by independent assessment.

BILL ANALYSIS:

Section 1 of House Bill 492 creates additional criteria for individuals to obtain up to 130 hours per month of Personal Care Services. (The maximum allowed under current law is 80 hours.). To qualify for

O. Walker Reagan
Director



Research Division
(919) 733-2578

House PCS 492

Page 2

up to 50 additional hours of Personal Care Services the Medicaid recipient must meet all of the following criteria:

- The individual qualifies for Medicaid Personal Care Services as outlined in the current law.
- The individual requires an increased level of supervision.
- The individual requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- The individual requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- The individual exhibits safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.
- The individual has a physician's attestation that the individual meets the above criteria.

Based upon the physician attestation, the individual must receive an independent assessment to determine the number of hours of personal care services that are needed. The assessment must be conducted by a trained professional who is qualified to assess, and has experience in assessing, the needs of individuals with needs for the safeguards indicated in the above bullets.

Section 2 of the Proposed Committee Substitute for HB 492 authorizes the Department of Health and Human Services (Department) to reduce the rate for Personal Care Services in order to fund the additional service hours provided by the act and to remain within the budgeted amount of funds for Personal Care Services.

Section 3 of the Proposed Committee Substitute for HB 492 requires the Department to submit a Medicaid State Plan Amendment to the Centers for Medicare and Medicaid Services.

Section 4(a) of the Proposed Committee Substitute for HB 492 directs the Department to make an interim report on or before August 1, 2013, to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The report must include (i) an estimate of the number of Medicaid recipients eligible for Personal Care Services under the act, (ii) an estimate of the number of hours potential recipients would require, (iii) a copy of the draft Medicaid State Plan Amendment to be submitted to CMS for approval, (iv) an estimated timeline for approval with projected implementation date, and (v) the rate reductions necessary to implement the act.

Section 4(b) requires the Department to provide a report on the implementation of the act to the Joint Legislative Oversight Committee on Health and Human Services on or before November 1, 2013.

EFFECTIVE DATE: The Proposed Committee Substitute for HB 492 changes the effective date to July 1, 2013.

**Amy Jo Johnson, staff to the House Health Committee, contributed to this summary.*



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 492

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

H492-ASH-8 [v.1]

Page 1 of 1

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

Date May 29, 2013, 2013

Senator Hise

1 moves to amend the bill on page 3, lines 3-5, by rewriting the lines to read:

2 "SECTION 3. On or before August 15, 2013, the Department of Health and Human
3 Services shall submit to the Centers for Medicare and Medicaid Services, a Medicaid State Plan
4 Amendment necessary to implement this act. The State Plan Amendment shall include an
5 effective date of July 1, 2013, or as soon after July 1, 2013, as allowed by the Centers for
6 Medicare and Medicaid Services.";

7
8 and on page 3, line 19, by rewriting the line to read:

9 "SECTION 5. Section 1 of this act becomes effective upon approval by the Centers
10 for Medicare and Medicaid Services of the Medicaid State Plan Amendment required in
11 Section 3 of this act. The Department of Health and Human Services shall provide notice of
12 State Plan Amendment approval by posting the effective date of the change on its Web site.
13 The remainder of the act is effective when it becomes law.".

SIGNED



Amendment Sponsor

SIGNED

Committee Chair if Senate Committee Amendment

ADOPTED

FAILED

TABLED



* H 4 9 2 - A S H - 8 - V - 1 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

D

HOUSE BILL 399
Committee Substitute Favorable 4/3/13
Committee Substitute #2 Favorable 4/24/13
Fourth Edition Engrossed 4/30/13
PROPOSED SENATE COMMITTEE SUBSTITUTE H399-PCS10411-TK-40

Short Title: Amend Laws Pertaining to DHHS.-AB

(Public)

Sponsors:

Referred to:

March 21, 2013

A BILL TO BE ENTITLED
AN ACT TO MAKE CHANGES REQUESTED BY THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES TO LAWS PERTAINING TO CHILD ABUSE, NEGLECT,
AND DEPENDENCY; MEDICAID; AND PUBLIC HEALTH.
The General Assembly of North Carolina enacts:

**PART I. CHANGES TO LAWS PERTAINING TO CHILD ABUSE, NEGLECT, AND
DEPENDENCY**

SECTION 1. G.S. 7B-507 reads as rewritten:

"§ 7B-507. Reasonable efforts.

(a) An order placing or continuing the placement of a juvenile in the custody or placement responsibility of a county department of social services, whether an order for continued nonsecure custody, a dispositional order, or a review order:

- (1) Shall contain a finding that the juvenile's continuation in or return to the juvenile's own home would be contrary to the juvenile's best interest;
- (2) Shall contain specific findings as to whether a county department of social services has made reasonable efforts to either prevent the need for placement or eliminate the need for placement of the juvenile, unless the court has previously determined under subsection (b) of this section that such efforts are not required or shall cease;
- (3) Shall contain findings as to whether a county department of social services should continue to make reasonable efforts to prevent or eliminate the need for placement of the juvenile, unless the court has previously determined or determines under subsection (b) of this section that such efforts are not required or shall cease;
- (4) Shall specify that the juvenile's placement and care are the responsibility of the county department of social services and that the department is to provide or arrange for the foster care or other placement of the juvenile. After considering the department's recommendations, the court may order a specific placement the court finds to be in the juvenile's best interest; and
- (5) May provide for services or other efforts aimed at returning the juvenile to a safe home or at achieving another permanent plan for the juvenile.



* H 3 9 9 - P C S 1 0 4 1 1 - T K - 4 0 *

1 A finding that reasonable efforts have not been made by a county department of social services
2 shall not preclude the entry of an order authorizing the juvenile's placement when the court
3 finds that placement is necessary for the protection of the juvenile. Where efforts to prevent the
4 need for the juvenile's placement were precluded by an immediate threat of harm to the
5 juvenile, the court may find that the placement of the juvenile in the absence of such efforts
6 was reasonable.

7 (b) In any order placing a juvenile in the custody or placement responsibility of a
8 county department of social services, whether an order for continued nonsecure custody, a
9 dispositional order, or a review order, the court may direct that reasonable efforts to eliminate
10 the need for placement of the juvenile shall not be required or shall cease if the court makes
11 written findings of fact that:

- 12 (1) Such efforts clearly would be futile or would be inconsistent with the
13 juvenile's health, safety, and need for a safe, permanent home within a
14 reasonable period of time;
- 15 (2) A court of competent jurisdiction has determined that the parent has
16 subjected the child to aggravated circumstances as defined in G.S. 7B-101;
- 17 (3) A court of competent jurisdiction has terminated involuntarily the parental
18 rights of the parent to another child of the parent; or
- 19 (4) A court of competent jurisdiction has determined that: the parent has
20 committed murder or voluntary manslaughter of another child of the parent;
21 has aided, abetted, attempted, conspired, or solicited to commit murder or
22 voluntary manslaughter of the child or another child of the parent; ~~or~~ has
23 committed a felony assault resulting in serious bodily injury to the child or
24 another child of the ~~parent~~; has committed sexual abuse against the
25 child or another child of the parent; or has been required to register as a sex
26 offender on any government-administered registry.

27 (c) When the court determines that reunification efforts are not required or shall cease,
28 the court shall order a plan for permanence as soon as possible, after providing each party with
29 a reasonable opportunity to prepare and present evidence. If the court's determination to cease
30 reunification efforts is made in a hearing that was duly and timely noticed as a permanency
31 planning hearing, then the court may immediately proceed to consider all of the criteria
32 contained in G.S. 7B-907(b), make findings of fact, and set forth the best plan of care to
33 achieve a safe, permanent home within a reasonable period of time. If the court's decision to
34 cease reunification efforts arises in any other hearing, the court shall schedule a subsequent
35 hearing within 30 days to address the permanent plan in accordance with G.S. 7B-907. At any
36 hearing at which the court orders that reunification efforts shall cease, the affected parent,
37 guardian, or custodian may give notice to preserve the right to appeal that order in accordance
38 with G.S. 7B-1001. The party giving notice shall be permitted to make a detailed offer of proof
39 as to any evidence that party sought to offer in opposition to cessation of reunification that the
40 court refused to admit.

41 (d) In determining reasonable efforts to be made with respect to a juvenile and in
42 making such reasonable efforts, the juvenile's health and safety shall be the paramount concern.
43 Reasonable efforts to preserve or reunify families may be made concurrently with efforts to
44 plan for the juvenile's adoption, to place the juvenile with a legal guardian, or to place the
45 juvenile in another permanent arrangement."

46 **SECTION 2.** G.S. 7B-909 reads as rewritten:

47 **"§ 7B-909. Review of agency's plan for placement.**

48 (a) The director of social services or the director of the licensed private child-placing
49 agency shall promptly notify the clerk to calendar the case for review of the department's or
50 agency's plan for the juvenile at a session of court scheduled for the hearing of juvenile matters
51 in any case where matters. The review shall be held within six months of accepting a

1 relinquishment of a juvenile for adoption under the provisions of Part 7 of Article 3 of Chapter
2 48 of the General Statutes unless the juvenile has become the subject of a decree of adoption.

3 (1) ~~One parent has surrendered a juvenile for adoption under the provisions of~~
4 ~~Part 7 of Article 3 of Chapter 48 of the General Statutes and the termination~~
5 ~~of parental rights proceedings have not been instituted against the~~
6 ~~nonsurrendering parent within six months of the surrender by the other~~
7 ~~parent, or~~

8 (2) ~~Both parents have surrendered a juvenile for adoption under the provisions~~
9 ~~of Part 7 of Article 3 of Chapter 48 of the General Statutes and that juvenile~~
10 ~~has not been placed for adoption within six months from the date of the more~~
11 ~~recent parental surrender.~~

12 (b) Repealed by 2007-276, s. 6, effective October 1, 2007.

13 (c) Notification of the court under this section shall be by a petition for review. ~~The~~
14 ~~petition shall set forth the circumstances necessitating the review under subsection (a) of this~~
15 ~~section.~~ The review shall be conducted within 30 days following the filing of the petition for
16 review unless the court shall otherwise direct. The court shall conduct reviews every six
17 months until the juvenile is the subject of a decree of adoption. The initial review and all
18 subsequent reviews shall be conducted pursuant to G.S. 7B-908. Any individual whose parental
19 rights have been terminated shall not be considered a party to the review unless an appeal of the
20 order terminating parental rights is pending, and a court has stayed the order pending the
21 appeal."
22

23 **PART II. CHANGES TO LAWS PERTAINING TO MEDICAID**

24 **SECTION 3. G.S. 108A-70.5(b)(2) reads as rewritten:**

25 "(2) Estate. – All the real and personal property considered assets of the estate
26 available for the discharge of debt pursuant to G.S. 28A-15-1. The
27 Department has all rights available to estate creditors, including the right to
28 qualify as personal representative or collector of an estate. For individuals
29 who have received benefits under a qualified long-term care partnership
30 policy as described in G.S. 108A-70.4, "estate" also includes any other real
31 and personal property and other assets in which the individual had any legal
32 title or interest at the time of death (to the extent of such interest), including
33 assets conveyed to a survivor, heir, or assign of the deceased individual
34 through joint tenancy, tenancy in common, survivorship, life estate, living
35 trust, or other arrangement."

36 **SECTION 4. G.S. 28A-14-1(b) reads as rewritten:**

37 "(b) Prior to filing the proof of notice required by G.S. 28A-14-2, every personal
38 representative and collector shall personally deliver or send by first class mail to the last known
39 address a copy of the notice required by subsection (a) of this section to all persons, firms, and
40 corporations having unsatisfied claims against the decedent who are actually known or can be
41 reasonably ascertained by the personal representative or collector within 75 days after the
42 granting of ~~letters.~~ letters and, if at the time of the decedent's death the decedent was receiving
43 medical assistance as defined by G.S. 108A-70.5(b)(1), to the Department of Health and
44 Human Services, Division of Medical Assistance. Provided, however, no notice shall be
45 required to be delivered or mailed with respect to any claim that is recognized as a valid claim
46 by the personal representative or collector."

47 **SECTION 5. G.S. 28A-19-6(a) reads as rewritten:**

48 "(a) After payment of costs and expenses of administration, the claims against the estate
49 of a decedent must be paid in the following order:

50 First class. Claims which by law have a specific lien on property to an amount not
51 exceeding the value of such property.

1 Second class. Funeral expenses to the extent of three thousand five hundred dollars
2 (\$3,500). This limitation shall not include burial place or gravestone. The preferential limitation
3 herein granted shall be construed to be only a limit with respect to preference of payment and
4 shall not be construed to be a limitation on reasonable funeral expenses which may be incurred;
5 nor shall the preferential limitation of payment in the amount of three thousand five hundred
6 dollars (\$3,500) be diminished by any Veterans Administration, social security or other federal
7 governmental benefits awarded to the estate of the decedent or to the decedent's beneficiaries.

8 Third class. Costs associated with gravestones and reasonable costs for the purchase of a
9 suitable burial place as provided in G.S. 28A-19-9 to the extent of one thousand five hundred
10 dollars (\$1,500). The preferential limitation herein granted shall be construed to be only a limit
11 with respect to preference of payment and shall not be construed to be a limitation on
12 reasonable gravestone or burial place expenses which may be incurred; nor shall the
13 preferential limitation of payment in the amount of one thousand five hundred dollars (\$1,500)
14 be diminished by any Veterans Administration, social security or other federal governmental
15 benefits awarded to the estate of the decedent or to the decedent's beneficiaries.

16 Fourth class. All dues, taxes, and other claims with preference under the laws of the United
17 States.

18 Fifth class. All dues, taxes, and other claims with preference under the laws of the State of
19 North Carolina and its subdivisions.

20 Sixth class. Judgments of any court of competent jurisdiction within the State, docketed and
21 in force, to the extent to which they are a lien on the property of the decedent at the decedent's
22 death. The Department of Health and Human Services is a sixth-class creditor for purposes of
23 determining the order of claims against the estate; provided, however, that judgments in favor
24 of other sixth-class creditors docketed and in force before the Department seeks recovery for
25 medical assistance shall be paid prior to recovery by the Department.

26 Seventh class. Wages due to any employee employed by the decedent, which claim for
27 wages shall not extend to a period of more than 12 months next preceding the death; or if such
28 employee was employed for the year current at the decease, then from the time of such
29 employment; for medical services within the 12 months preceding the decease; for drugs and
30 all other medical supplies necessary for the treatment of such decedent during the last illness of
31 such decedent, said period of last illness not to exceed 12 months.

32 Eighth class. A claim for equitable distribution.

33 Ninth class. All other claims."

34 **SECTION 6.** Article 8A of Chapter 36C of the General Statutes is amended by
35 adding a new section to read as follows:

36 **"§ 36C-8-818. Notice of deceased Medicaid beneficiaries.**

37 If a trust was established by a person who at the time of that person's death was receiving
38 medical assistance, as defined in G.S. 108A-70.5(b)(1), and the trust was revocable at the time
39 of that person's death, then any trustee of that trust who knows of the medical assistance within
40 90 days of the person's death shall provide notice of that person's death to the Department of
41 Health and Human Services, Division of Medical Assistance within 90 days of the person's
42 death."

43 **SECTION 7.** G.S. 108C-3 reads as rewritten:

44 **"§ 108C-3. Medicaid and Health Choice provider screening.**

45 ...

46 (c) Limited Categorical Risk Provider Types. – The following provider types are hereby
47 designated as "limited" categorical risk:

48 ...

49 (12) Physician or nonphysician practitioners (including nurse practitioners,
50 CRNAs, physician assistants, physician extenders, occupational therapists,

speech/language pathologists, chiropractors, and audiologists), optometrists, dentists and orthodontists, and medical groups or clinics.

...

(15) Hearing aid dealers.

(16) Portable X-ray suppliers.

(17) Religious nonmedical health care institutions.

(18) Registered dieticians.

(19) Clearinghouses, billing agents, and alternate payees.

(20) Local health departments.

...

(e) Moderate Categorical Risk Provider Types. – The following provider types are hereby designated as "moderate" categorical risk:

...

(3) Critical Access Behavioral Health Agencies.

(4) ~~Dentists and orthodontists.~~

(5) Hospice organizations.

...

(13) Revalidating agencies providing private duty nursing, home health, personal care services or in-home care services, or home infusion.

(14) Nonemergency medical transportation.

...."

PART III. CHANGES TO LAWS PERTAINING TO PUBLIC HEALTH

SECTION 8. G.S. 130A-22(b3) reads as rewritten:

"(b3) The Secretary may impose an administrative penalty on a person who violates Article 19A or 19B of this Chapter or any rules adopted pursuant to Article 19A or 19B of this Chapter. Each day of a continuing violation is a separate violation. The penalty shall not exceed ~~one-five~~ thousand dollars ~~(\$1,000)~~ (\$5,000) for each day the violation continues for Article 19A of this Chapter. The penalty shall not exceed ~~seven-hundred-fifty-five~~ thousand dollars ~~(\$750.00)~~ (\$5,000) for each day the violation continues for Article 19B of this Chapter. The penalty authorized by this section does not apply to a person who is not required to be certified under Article 19A or 19B."

SECTION 9. G.S. 130A-101(b) reads as rewritten:

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

SECTION 10. G.S. 130A-209(a) reads as rewritten:

"§ 130A-209. Incidence reporting of cancer; charge for collection if failure to report.

(a) ~~All~~ By no later than October 1, 2014, all health care facilities and health care providers that detect, diagnose, or treat cancer or benign brain or central nervous system tumors shall submit by electronic transmission a report to the central cancer registry each diagnosis of cancer or benign brain or central nervous system tumors in any person who is screened, diagnosed, or treated by the facility or provider. The electronic transmission of these reports shall be in a format prescribed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Program of Cancer Registries. The reports shall be made within six months ~~of~~ after diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report."

PART IV. EFFECTIVE DATE

SECTION 11. This act becomes effective October 1, 2013.



HOUSE BILL 399: Amend Laws Pertaining to DHHS.-AB

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Judiciary II. If fav, re-ref to Finance	Date:	May 28, 2013
Introduced by:	Reps. Burr, Hollo, Avila	Prepared by:	Amy Jo Johnson*
Analysis of:	Fourth Edition		Committee Counsel

SUMMARY: *House Bill 399 makes changes to statutes pertaining to child abuse, neglect and dependency, Medicaid, and Public Health, as requested by the Department of Health and Human Services.*

Part I: Changes to Laws Pertaining to Child Abuse, Neglect, and Dependency.

Section 1 clarifies G.S. 7B-507(a)(2). Court orders pertaining to the department of social services' custody or placement responsibility of a juvenile are required to include case specific findings as to the reasonable efforts made by the department to either prevent or eliminate the need for placement of a juvenile.

In order for a State to be eligible for grants for child abuse/neglect prevention and treatment programs under the Child Abuse Prevention and Treatment Reauthorization Act of 2010, courts must be allowed to not pursue reunification when a parent is found to have sexually abused a child or a parent is listed on a sex offender registry. **Section 1** adds language consistent with requirements under 42 USCA 5106a.

Section 2 amends G.S. 7B-909 to clarify that the review of an agency's plan for placement of a juvenile under relinquishment must take place within six months of accepting the relinquishment. The reviews continue every six months until juvenile is adopted. Similar placement reviews after termination of parental rights are provided for in G.S. 7B-908.

Part II: Changes to Laws Pertaining to Medicaid

Sections 3, 4, 5, and 6 of the bill address Medicaid Estate Recovery.

42 USC 1396p(b) provides that the state must seek recovery for medical assistance paid on behalf of individuals in certain circumstances. The Omnibus Budget Reconciliation Act of 1993 made enactment of a Medicaid estate recovery program a condition for receiving federal funding for that state's Medicaid program.

The North Carolina Medicaid Estate Recovery Plan is established by G.S. 108A-70.5. The purpose of the estate recovery plan is "to recover from the recipients of medical assistance an equitable amount of the state and federal shares of the cost paid to the recipient."

Section 3 of the bill provides that the Department of Health and Human Services (Department) has all rights available to estate creditors, including the right to qualify as Personal Representative or Collector of an estate.

Section 4 of the bill gives the Division of Medical Assistance (DMA) notice as a known creditor when an estate is opened where the decedent received medical assistance.

Section 5 clarifies that the Department is a sixth-class creditor for purposes of determining order of claims against the estate. It specifies that judgments in favor of other sixth-class creditors docketed and

O. Walker Reagan
Director



Research Division
(919) 733-2578

House Bill 399

Page 2

in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department

Section 6 requires trustees of revocable trusts and who know the person received medical assistance to give notice to the DMA within 90 days of the death of a trust beneficiary.

Section 7 of the bill addresses Medicaid and Health Choice provider and enrollment screening. Pursuant to federal regulation, all Medicaid and Health Choice providers must be screened according to one of three risk levels: limited, moderate, and high. **Section 7** adds new providers to these already established categories.

Part III: Changes to the Laws Pertaining to Public Health

Section 8 increases the potential penalty for violations of the DHHS Lead-Based Paint Program. The potential penalty is increased to not exceed \$5,000 per day each violation continues. Federal regulations establish a minimum penalty for State programs of \$5,000 per day. 42 CFR 745.327.

Section 9 changes the requirements to file a birth certificate for a live birth in the State with the local county registrar from ten days to five days. Under G.S. 130A-101 there are currently two different time limits: one for births in a hospital or medical facility (five days) and one for all other births (ten days). House Bill 399 would create one standard time limit for all births.

Section 10 makes a change to the central cancer registry, established under G.S. 130A-208. G.S. 130A-209 requires all health care providers and facilities to report each diagnosis of cancer or benign brain or central nervous system tumors. House Bill 399 would require that this reporting be done electronically by October 1, 2014, and done so in a format prescribed by the US DHHS, the Centers for Disease Control and Prevention, National Program of Cancer Registries.

EFFECTIVE DATE: This act becomes effective October 1, 2013.

**Susan Barham, Research Assistant, and Susan Sitze, Staff Attorney, substantially contributed to this summary.*



NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 399

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

Page 1 of 1

H399-ATK-70 [v.1]

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

Date _____, 2013

Senator Wade

1 moves to amend the bill on page 5, lines 31-35, by rewriting the lines to read:
2

3 "SECTION 9. G.S. 130A-101(b) reads as rewritten:

4 "(b) When a birth occurs in a hospital or other medical facility, the person in charge of
5 the facility shall obtain the personal data, prepare the certificate, secure the signatures required
6 by the certificate and file it with the local registrar within ~~five~~ ten days after the birth. The
7 physician or other person in attendance shall provide the medical information required by the
8 certificate."
9
0

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____



* H 3 9 9 - A T K - 7 0 - V - 1 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

4

HOUSE BILL 399
Committee Substitute Favorable 4/3/13
Committee Substitute #2 Favorable 4/24/13
Fourth Edition Engrossed 4/30/13

Short Title: Amend Laws Pertaining to DHHS.-AB

(Public)

Sponsors:

Referred to:

March 21, 2013

A BILL TO BE ENTITLED
AN ACT TO MAKE CHANGES REQUESTED BY THE DEPARTMENT OF HEALTH
AND HUMAN SERVICES TO LAWS PERTAINING TO CHILD ABUSE, NEGLECT,
AND DEPENDENCY; MEDICAID; AND PUBLIC HEALTH.

The General Assembly of North Carolina enacts:

**PART I. CHANGES TO LAWS PERTAINING TO CHILD ABUSE, NEGLECT, AND
DEPENDENCY**

SECTION 1. G.S. 7B-507 reads as rewritten:

"§ 7B-507. Reasonable efforts.

(a) An order placing or continuing the placement of a juvenile in the custody or placement responsibility of a county department of social services, whether an order for continued nonsecure custody, a dispositional order, or a review order:

- (1) Shall contain a finding that the juvenile's continuation in or return to the juvenile's own home would be contrary to the juvenile's best interest;
- (2) Shall contain specific findings as to whether a county department of social services has made reasonable efforts to either prevent the need for placement or eliminate the need for placement of the juvenile, unless the court has previously determined under subsection (b) of this section that such efforts are not required or shall cease;
- (3) Shall contain findings as to whether a county department of social services should continue to make reasonable efforts to prevent or eliminate the need for placement of the juvenile, unless the court has previously determined or determines under subsection (b) of this section that such efforts are not required or shall cease;
- (4) Shall specify that the juvenile's placement and care are the responsibility of the county department of social services and that the department is to provide or arrange for the foster care or other placement of the juvenile. After considering the department's recommendations, the court may order a specific placement the court finds to be in the juvenile's best interest; and
- (5) May provide for services or other efforts aimed at returning the juvenile to a safe home or at achieving another permanent plan for the juvenile.

A finding that reasonable efforts have not been made by a county department of social services shall not preclude the entry of an order authorizing the juvenile's placement when the court



1 finds that placement is necessary for the protection of the juvenile. Where efforts to prevent the
2 need for the juvenile's placement were precluded by an immediate threat of harm to the
3 juvenile, the court may find that the placement of the juvenile in the absence of such efforts
4 was reasonable.

5 (b) In any order placing a juvenile in the custody or placement responsibility of a
6 county department of social services, whether an order for continued nonsecure custody, a
7 dispositional order, or a review order, the court may direct that reasonable efforts to eliminate
8 the need for placement of the juvenile shall not be required or shall cease if the court makes
9 written findings of fact that:

10 (1) Such efforts clearly would be futile or would be inconsistent with the
11 juvenile's health, safety, and need for a safe, permanent home within a
12 reasonable period of time;

13 (2) A court of competent jurisdiction has determined that the parent has
14 subjected the child to aggravated circumstances as defined in G.S. 7B-101;

15 (3) A court of competent jurisdiction has terminated involuntarily the parental
16 rights of the parent to another child of the parent; or

17 (4) A court of competent jurisdiction has determined that: the parent has
18 committed murder or voluntary manslaughter of another child of the parent;
19 has aided, abetted, attempted, conspired, or solicited to commit murder or
20 voluntary manslaughter of the child or another child of the parent; ~~or~~ has
21 committed a felony assault resulting in serious bodily injury to the child or
22 another child of the ~~parent-parent~~; has committed sexual abuse against the
23 child or another child of the parent; or has been required to register as a sex
24 offender on any government-administered registry.

25 (c) When the court determines that reunification efforts are not required or shall cease,
26 the court shall order a plan for permanence as soon as possible, after providing each party with
27 a reasonable opportunity to prepare and present evidence. If the court's determination to cease
28 reunification efforts is made in a hearing that was duly and timely noticed as a permanency
29 planning hearing, then the court may immediately proceed to consider all of the criteria
30 contained in G.S. 7B-907(b), make findings of fact, and set forth the best plan of care to
31 achieve a safe, permanent home within a reasonable period of time. If the court's decision to
32 cease reunification efforts arises in any other hearing, the court shall schedule a subsequent
33 hearing within 30 days to address the permanent plan in accordance with G.S. 7B-907. At any
34 hearing at which the court orders that reunification efforts shall cease, the affected parent,
35 guardian, or custodian may give notice to preserve the right to appeal that order in accordance
36 with G.S. 7B-1001. The party giving notice shall be permitted to make a detailed offer of proof
37 as to any evidence that party sought to offer in opposition to cessation of reunification that the
38 court refused to admit.

39 (d) In determining reasonable efforts to be made with respect to a juvenile and in
40 making such reasonable efforts, the juvenile's health and safety shall be the paramount concern.
41 Reasonable efforts to preserve or reunify families may be made concurrently with efforts to
42 plan for the juvenile's adoption, to place the juvenile with a legal guardian, or to place the
43 juvenile in another permanent arrangement."

44 **SECTION 2. G.S. 7B-909 reads as rewritten:**

45 **"§ 7B-909. Review of agency's plan for placement.**

46 (a) The director of social services or the director of the licensed private child-placing
47 agency shall promptly notify the clerk to calendar the case for review of the department's or
48 agency's plan for the juvenile at a session of court scheduled for the hearing of juvenile ~~matters~~
49 ~~in any case where matters.~~ The review shall be held within six months of accepting a
50 relinquishment of a juvenile for adoption under the provisions of Part 7 of Article 3 of Chapter
51 48 of the General Statutes unless the juvenile has become the subject of a decree of adoption.

- 1 (1) ~~One parent has surrendered a juvenile for adoption under the provisions of~~
2 ~~Part 7 of Article 3 of Chapter 48 of the General Statutes and the termination~~
3 ~~of parental rights proceedings have not been instituted against the~~
4 ~~nonsurrendering parent within six months of the surrender by the other~~
5 ~~parent, or~~
6 (2) ~~Both parents have surrendered a juvenile for adoption under the provisions~~
7 ~~of Part 7 of Article 3 of Chapter 48 of the General Statutes and that juvenile~~
8 ~~has not been placed for adoption within six months from the date of the more~~
9 ~~recent parental surrender.~~
10 (b) Repealed by 2007-276, s. 6, effective October 1, 2007.
11 (c) Notification of the court under this section shall be by a petition for review. The
12 ~~petition shall set forth the circumstances necessitating the review under subsection (a) of this~~
13 ~~section.~~ The review shall be conducted within 30 days following the filing of the petition for
14 review unless the court shall otherwise direct. The court shall conduct reviews every six
15 months until the juvenile is the subject of a decree of adoption. The initial review and all
16 subsequent reviews shall be conducted pursuant to G.S. 7B-908. Any individual whose parental
17 rights have been terminated shall not be considered a party to the review unless an appeal of the
18 order terminating parental rights is pending, and a court has stayed the order pending the
19 appeal."
20

21 **PART II. CHANGES TO LAWS PERTAINING TO MEDICAID**

22 **SECTION 3. G.S. 108A-70.5(b)(2) reads as rewritten:**

- 23 "(2) Estate. – All the real and personal property considered assets of the estate
24 available for the discharge of debt pursuant to G.S. 28A-15-1. The
25 Department has all rights available to estate creditors, including the right to
26 qualify as personal representative or collector of an estate. For individuals
27 who have received benefits under a qualified long-term care partnership
28 policy as described in G.S. 108A-70.4, "estate" also includes any other real
29 and personal property and other assets in which the individual had any legal
30 title or interest at the time of death (to the extent of such interest), including
31 assets conveyed to a survivor, heir, or assign of the deceased individual
32 through joint tenancy, tenancy in common, survivorship, life estate, living
33 trust, or other arrangement."

34 **SECTION 4. G.S. 28A-14-1(b) reads as rewritten:**

- 35 "(b) Prior to filing the proof of notice required by G.S. 28A-14-2, every personal
36 representative and collector shall personally deliver or send by first class mail to the last known
37 address a copy of the notice required by subsection (a) of this section to all persons, firms, and
38 corporations having unsatisfied claims against the decedent who are actually known or can be
39 reasonably ascertained by the personal representative or collector within 75 days after the
40 granting of ~~letters~~ letters and, if at the time of the decedent's death the decedent was receiving
41 medical assistance as defined by G.S. 108A-70.5(b)(1), to the Department of Health and
42 Human Services, Division of Medical Assistance. Provided, however, no notice shall be
43 required to be delivered or mailed with respect to any claim that is recognized as a valid claim
44 by the personal representative or collector."

45 **SECTION 5. G.S. 28A-19-6(a) reads as rewritten:**

- 46 "(a) After payment of costs and expenses of administration, the claims against the estate
47 of a decedent must be paid in the following order:

48 First class. Claims which by law have a specific lien on property to an amount not
49 exceeding the value of such property.

50 Second class. Funeral expenses to the extent of three thousand five hundred dollars
51 (\$3,500). This limitation shall not include burial place or gravestone. The preferential limitation

herein granted shall be construed to be only a limit with respect to preference of payment and shall not be construed to be a limitation on reasonable funeral expenses which may be incurred; nor shall the preferential limitation of payment in the amount of three thousand five hundred dollars (\$3,500) be diminished by any Veterans Administration, social security or other federal governmental benefits awarded to the estate of the decedent or to the decedent's beneficiaries.

Third class. Costs associated with gravestones and reasonable costs for the purchase of a suitable burial place as provided in G.S. 28A-19-9 to the extent of one thousand five hundred dollars (\$1,500). The preferential limitation herein granted shall be construed to be only a limit with respect to preference of payment and shall not be construed to be a limitation on reasonable gravestone or burial place expenses which may be incurred; nor shall the preferential limitation of payment in the amount of one thousand five hundred dollars (\$1,500) be diminished by any Veterans Administration, social security or other federal governmental benefits awarded to the estate of the decedent or to the decedent's beneficiaries.

Fourth class. All dues, taxes, and other claims with preference under the laws of the United States.

Fifth class. All dues, taxes, and other claims with preference under the laws of the State of North Carolina and its subdivisions.

Sixth class. Judgments of any court of competent jurisdiction within the State, docketed and in force, to the extent to which they are a lien on the property of the decedent at the decedent's death. The Department of Health and Human Services is a sixth-class creditor for purposes of determining the order of claims against the estate; provided, however, that judgments in favor of other sixth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

Seventh class. Wages due to any employee employed by the decedent, which claim for wages shall not extend to a period of more than 12 months next preceding the death; or if such employee was employed for the year current at the decease, then from the time of such employment; for medical services within the 12 months preceding the decease; for drugs and all other medical supplies necessary for the treatment of such decedent during the last illness of such decedent, said period of last illness not to exceed 12 months.

Eighth class. A claim for equitable distribution.

Ninth class. All other claims."

SECTION 6. Article 8A of Chapter 36C of the General Statutes is amended by adding a new section to read as follows:

"§ 36C-8-818. Notice of deceased Medicaid beneficiaries.

If a trust was established by a person who at the time of that person's death was receiving medical assistance, as defined in G.S. 108A-70.5(b)(1), and the trust was revocable at the time of that person's death, then any trustee of that trust who knows of the medical assistance within 90 days of the person's death shall provide notice of that person's death to the Department of Health and Human Services, Division of Medical Assistance within 90 days of the person's death."

SECTION 7. G.S. 108C-3 reads as rewritten:

"§ 108C-3. Medicaid and Health Choice provider screening.

...
(c) Limited Categorical Risk Provider Types. – The following provider types are hereby designated as "limited" categorical risk:

- ...
(12) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, and audiologists), optometrists, dentists and orthodontists, and medical groups or clinics.

...

- (15) Hearing aid dealers.
- (16) Portable X-ray suppliers.
- (17) Religious nonmedical health care institutions.
- (18) Registered dieticians.
- (19) Clearinghouses, billing agents, and alternate payees.
- (20) Local health departments.

(e) Moderate Categorical Risk Provider Types. – The following provider types are hereby designated as "moderate" categorical risk:

- (3) Critical Access Behavioral Health Agencies.
- (4) ~~Dentists and orthodontists.~~
- (5) Hospice organizations.
- (13) Revalidating agencies providing private duty nursing, home health, personal care services or in-home care services, or home infusion.
- (14) Nonemergency medical transportation.

PART III. CHANGES TO LAWS PERTAINING TO PUBLIC HEALTH

SECTION 8. G.S. 130A-22(b3) reads as rewritten:

"(b3) The Secretary may impose an administrative penalty on a person who violates Article 19A or 19B of this Chapter or any rules adopted pursuant to Article 19A or 19B of this Chapter. Each day of a continuing violation is a separate violation. The penalty shall not exceed ~~one five thousand dollars (\$1,000)~~ (\$5,000) for each day the violation continues for Article 19A of this Chapter. The penalty shall not exceed ~~seven hundred fiftyfive thousand~~ dollars (\$750.00) (\$5,000) for each day the violation continues for Article 19B of this Chapter. The penalty authorized by this section does not apply to a person who is not required to be certified under Article 19A or 19B."

SECTION 9. G.S. 130A-101(a) reads as rewritten:

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

SECTION 10. G.S. 130A-209(a) reads as rewritten:

"§ 130A-209. Incidence reporting of cancer; charge for collection if failure to report.

(a) ~~All~~ By no later than October 1, 2014, all health care facilities and health care providers that detect, diagnose, or treat cancer or benign brain or central nervous system tumors shall submit by electronic transmission a report to the central cancer registry each diagnosis of cancer or benign brain or central nervous system tumors in any person who is screened, diagnosed, or treated by the facility or provider. The electronic transmission of these reports shall be in a format prescribed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Program of Cancer Registries. The reports shall be made within six months ~~of after~~ after diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report."

PART IV. EFFECTIVE DATE

SECTION 11. This act becomes effective October 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

1

HOUSE BILL 459*

Short Title: Chronic Care Coordination Act.

(Public)

Sponsors: Representatives Dollar, Murry, Holló, and Lambeth (Primary Sponsors).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Health and Human Services, if favorable, Appropriations.

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
COORDINATE CHRONIC DISEASE CARE.

Whereas, chronic disease is recognized as the leading cause of disability and death in the United States, and accounts for 1,700,000 deaths or 70% of all deaths in the United States each year; and

Whereas, chronic diseases such as heart disease, hypertension, stroke, cancer, respiratory diseases, diabetes, and obesity are among the most prevalent, costly, and preventable of all health problems in North Carolina; and

Whereas, implementing prevention programs around multiple chronic conditions could help North Carolina reduce the overall financial burden of chronic illness within public programs such as Medicaid and Health Choice for Children and within the State Employees Health Insurance Plan; and

Whereas, the inefficient coordination of care for persons with chronic health conditions has led not only to higher costs but to poorer health outcomes for the most vulnerable populations within North Carolina; and

Whereas, preventing and treating chronic disease is an important public health initiative that will improve the quality of life for North Carolinians affected by these conditions and also reduce State costs for Medicaid, Health Choice, and the State Health Plan; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as The Chronic Care Coordination Act.

SECTION 2. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 4A. Chronic Care Coordination.

"§ 130A-222.5. Department to coordinate chronic care initiatives.

The Department's Divisions of Public Health and Medical Assistance and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees shall collaborate to reduce the incidence of chronic disease and improve chronic care coordination within the State by doing all of the following:

- (1) Identifying goals and benchmarks for the reduction of chronic disease.
- (2) Developing wellness and prevention plans specifically tailored to each of the Divisions.
- (3) Submitting an annual report on or before January 1 of each odd-numbered year to the Senate Appropriations Committee on Health and Human



* H 4 5 9 - V - 1 *

Services, the House Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division that includes at least all of the following:

- a. The financial impact and magnitude of the chronic health conditions in this State that are most likely to cause death and disability, including, but not limited to, chronic cardiovascular disease, oncology, stroke, chronic lung disease, and chronic metabolic disease. As used in this subdivision, the term "chronic cardiovascular disease" includes heart disease and hypertension; the term "chronic metabolic disease" includes diabetes and obesity; and the term "chronic lung disease" means asthma and chronic obstructive pulmonary disease.
- b. An assessment of the benefits derived from wellness and prevention programs and activities implemented within the State with the goal of coordinating chronic care. This assessment shall include a breakdown of the amount of all State, federal, and other funds appropriated to the Department for wellness and prevention programs and activities for the detection, prevention, and treatment of persons with multiple chronic health conditions, at least one of which is a condition identified in sub-subdivision a. of this subdivision.
- c. A description of the level of coordination among the Divisions of Public Health and Medical Assistance and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees with respect to activities, programs, and public education on the prevention, treatment, and management of the chronic health conditions identified in sub-subdivision a. of this subdivision.
- d. Detailed action plans for care coordination of multiple chronic health conditions in the same patient, including a range of recommended legislative actions. The action plans shall identify proposed action steps to reduce the financial impact of the chronic health conditions identified in sub-subdivision a. of this subdivision, including (i) adjustment of hospital readmission rates, (ii) development of transitional care plans, (iii) implementation of comprehensive medication management, as described by the Patient-Centered Primary Care Collaborative, to help patients achieve improved clinical and therapeutic outcomes, and (iv) adoption of standards related to quality that are publicly reported evidence-based measures endorsed through a multistakeholder process such as the National Quality Forum. The action plans shall also identify expected outcomes of these proposed action steps during the succeeding fiscal biennium and establish benchmarks for coordinating care and reducing the incidence of multiple chronic health conditions.
- e. A detailed budget identifying all costs associated with implementing the action plans identified in sub-subdivision d. of this subdivision."

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

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

H

D

HOUSE BILL 459*
PROPOSED SENATE COMMITTEE SUBSTITUTE H459-CSSH-19 [v.3]

5/28/2013 8:11:26 PM

Short Title: Chronic Care Coordination Act.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED
AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO
COORDINATE CHRONIC DISEASE CARE.

Whereas, chronic disease is recognized as the leading cause of disability and death in the United States, and accounts for 1,700,000 deaths or 70% of all deaths in the United States each year; and

Whereas, chronic health conditions include diabetes and approximately 1.2 million people, accounting for 12% of the population, are living with diabetes in North Carolina, and the rate of diabetes is predicted to increase by 66% by 2025; and

Whereas, North Carolina is ranked 42nd in the area of diabetes in the 2012 American Health Rankings report; and according to the Centers for Disease Control, diabetes is the leading cause of kidney failure, nontraumatic lower-limb amputations, and new cases of blindness and other chronic diseases among adults in the United States; and

Whereas, chronic diseases such as heart disease, hypertension, stroke, cancer, respiratory diseases, diabetes, and obesity are among the most prevalent, costly, and preventable of all health problems in North Carolina; and

Whereas, chronic diseases and related injuries are responsible for approximately two-thirds of all deaths in North Carolina making effective coordination and utilization of resources addressing diabetes and other chronic diseases beneficial to all North Carolina residents;

Whereas, implementing prevention programs around multiple chronic conditions could help North Carolina reduce the overall financial burden of chronic illness within public programs such as Medicaid and Health Choice for Children and within the State Employees Health Insurance Plan; and

Whereas, the inefficient coordination of care for persons with chronic health conditions has led not only to higher costs but to poorer health outcomes for the most vulnerable populations within North Carolina; and

Whereas, preventing and treating chronic disease is an important public health initiative that will improve the quality of life for North Carolinians affected by these conditions and also reduce State costs for Medicaid, Health Choice, and the State Health Plan; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as The Chronic Care Coordination Act.

SECTION 2. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 4A. Chronic Care Coordination.



"§ 130A-222.5. Department to coordinate chronic care initiatives.

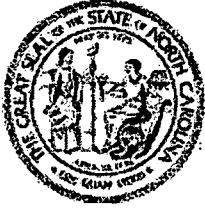
The Divisions of Public Health and Medical Assistance in the Department of Health and Human Services, and the State Health Plan for Teachers and State Employees Division in the Department of State Treasurer, shall collaborate to reduce the incidence of chronic disease and improve chronic care coordination. The Department of Health and Human Services shall take the lead role in coordinating the collaborative effort. Each Division's plans shall be tailored to the population the entity serves and shall provide measurable goals. Due to the prevalence of diabetes in the State, each Division shall develop a plan specifically aimed at reducing the incidence of diabetes, improving diabetes care, and controlling the complications associated with diabetes. The Divisions shall do all of the following:

- (1) Identify goals and benchmarks for the reduction of chronic disease.
- (2) Develop wellness and prevention plans specifically tailored to the population served by each of the Divisions.
- (3) Submit an annual report on or before January 1 of each odd-numbered year to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division that includes at least all of the following:
 - a. The financial impact and magnitude of the chronic health conditions in this State that are most likely to cause death and disability, including, but not limited to, chronic cardiovascular disease, oncology, stroke, chronic lung disease, and chronic metabolic disease. As used in this subdivision, the term "chronic cardiovascular disease" includes heart disease and hypertension; the term "chronic metabolic disease" includes diabetes and obesity; and the term "chronic lung disease" means asthma and chronic obstructive pulmonary disease. Information on chronic metabolic disease shall report data on diabetes separately so that it may be readily monitored and tracked.
 - b. An assessment of the benefits derived from wellness and prevention programs and activities implemented within the State with the goal of coordinating chronic care. This assessment shall include a breakdown of the amount of all State, federal, and other funds appropriated to each Division for wellness and prevention programs and activities for the detection, prevention, and treatment of persons with multiple chronic health conditions, at least one of which is a condition identified in sub-subdivision a. of this subdivision.
 - c. A description of the level of coordination among the Divisions of Public Health and Medical Assistance and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees with respect to activities, programs, and public education on the prevention, treatment, and management of the chronic health conditions identified in sub-subdivision a. of this subdivision.
 - d. Detailed action plans for care coordination of multiple chronic health conditions in the same patient, including a range of recommended legislative actions. The action plans shall identify proposed action steps to reduce the financial impact of the chronic health conditions identified in sub-subdivision a. of this subdivision, including (i) adjustment of hospital readmission rates, (ii) development of transitional care plans, (iii) implementation of comprehensive

1 medication management, as described by the Patient-Centered
2 Primary Care Collaborative, to help patients achieve improved
3 clinical and therapeutic outcomes, and (iv) adoption of standards
4 related to quality that are publicly reported evidence-based measures
5 endorsed through a multistakeholder process such as the National
6 Quality Forum. The action plans shall also identify expected
7 outcomes of these proposed action steps during the succeeding fiscal
8 biennium and establish benchmarks for coordinating care and
9 reducing the incidence of multiple chronic health conditions.

10 e. A detailed budget identifying all costs associated with implementing
11 the action plans identified in sub-subdivision d. of this subdivision."

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



HOUSE BILL 459: Chronic Care Coordination Act

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	Date:	May 28, 2013
Introduced by:	Reps. Dollar, Murry, Hollo, Lambeth	Prepared by:	Theresa Matula
Analysis of:	PCS to First Edition H459-CSSH-19		Committee Staff

SUMMARY: *House Bill 459 requires the Divisions of Public Health and Medical Assistance, Department of Health and Human Services, and the State Health Plan for Teachers and State Employees Division, Department of State Treasurer, to collaborate to reduce the incidence of chronic disease and improve chronic care coordination. The PCS includes a requirement that each Division develop a plan specifically aimed at reducing the incidence of diabetes, improving care, and controlling complications associated with diabetes.*

[As introduced, this bill was identical to S606, as introduced by Sens. Hise, Barringer, which is currently in Senate Health Care.]

BILL ANALYSIS: House Bill 459 creates a new Part 4A, "Chronic Care Coordination," of Article 7 ("Chronic Disease") of Chapter 130A of the General Statutes governing public health. The bill requires the Divisions of Public Health and Medical Assistance, Department of Health and Human Services, and the division in the Department of the State Treasurer responsible for the State Health Plan for Teachers and State Employees, to collaborate to reduce the incidence of chronic disease and improve chronic care coordination. The PCS requires that each Division's plans be tailored to the population the entity serves and provide measurable goals. The PCS also requires that each Division develop a plan specifically aimed at reducing the incidence of diabetes, improving diabetes care, and controlling the complications associated with diabetes. The Divisions shall do the following:

- Identify goals and benchmarks for the reduction of chronic disease.
- Develop wellness and prevention plans.
- Submit annual reports to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division. The reports shall include the following:
 - The financial impact and magnitude of the chronic health conditions most likely to cause death and disability, including certain conditions listed in the bill.
 - An assessment of benefits derived from wellness and prevention programs and activities designed to coordinate chronic care.
 - A description of the level of coordination among the agencies charged with care coordination responsibilities.
 - Detailed action plans for care coordination of multiple chronic health conditions in the same patient.
 - A detailed budget identifying all costs associated with implementing the mandated action plans.

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

Jan Paul, staff to the House Health Committee, contributed to this summary.

O. Walker Reagan
Director



Research Division
(919) 733-2578



**NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 492**

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

Page 1 of 1

H492-ASH-8 [v.1]

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

Date _____, 2013

Senator _____

1 moves to amend the bill on page 3, lines 3-5, by rewriting the lines to read:

2 "SECTION 3. On or before August 15, 2013, the Department of Health and Human
3 Services shall submit to the Centers for Medicare and Medicaid Services, a Medicaid State Plan
4 Amendment necessary to implement this act. The State Plan Amendment shall include an
5 effective date of July 1, 2013, or as soon after July 1, 2013, as allowed by the Centers for
6 Medicare and Medicaid Services.";

7
8 and on page 3, line 19, by rewriting the line to read:

9 "SECTION 5. Section 1 of this act becomes effective upon approval by the Centers
10 for Medicare and Medicaid Services of the Medicaid State Plan Amendment required in
11 Section 3 of this act. The Department of Health and Human Services shall provide notice of
12 State Plan Amendment approval by posting the effective date of the change on its Web site.
13 The remainder of the act is effective when it becomes law.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____



* H 4 9 2 - A S H - 8 - V - 1 *

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 5-29 TIME: 11 AM

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

Page	Name	Hometown	Sponsoring Senator
1.	Jazmyn Jones	Knightdale	Tom Apodaca
2.	Elaine Kearney	Pinehurst	Tillman
3.	Antoinette Dyer	Raleigh	Nesbit
4.	Jakira Sims	Avonville	Jackson
	Lillie Turlington	Clinton	Jackson
6.	Andrew Distell	Fayetteville	~~Merideth~~ Merideth
7.	Thomas ~~McBrayer~~	Hickory	Allran
8.	McBrayer		
9.			
10.			

Do not add names below the grid.

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

SENATE SERGEANT-AT-ARMS

COMMITTEE: **SENATE HEALTH CARE**

DATE: 05/29/13 ROOM: 544

1. ASHLEY MICKENS
2. STEVE WILSON
3. ED KESLER
4. BILLY FRITSCHER

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE

(Committee Name)

5-29-13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Jay Peters	CSS
KAREN GILLESPIE	BMS
JAY PETERS	CSS
Qu-Ann Pung	CSS
CHANDRIKA RAO	DPH/SCHS/CCR
Ashanti Scott	DPH/SCHS/CCR
JESSIE GOODMAN	DANS/DHSR
Tom Mylet	BAYADA Home Health
Lee D. Brown	BAYADA Home Health Care
Benton Albritten	ABC Carolinas
Alex Badger	CSS
D. O. J.	NERM
Matt Violl	CW Consult
Ted Fitzgerald	ccnc
Upendra Pith	Cap. Acces
Jon Wilk	NCA-ITF
Nikki G. Crecy	minority coalition
Thomas Hardaway	PHRMA

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Spurl Spurl	ND
Don Wobey	LIC
Christine Wason	ACS CAN
Leahy Hawthorne	UCAN
W. A. Froman	NCHC
Mary B. Re	AARP, re
Pam Shipman	Carle Place Inn.
JEFF BARNHART	MWC
Abraham T. Jones	NCAAC
Sam Horn	NCNA
Heather Barnett	Ward & Smith
Corye Dunn	TRNC
Annaliese Doloh	Dolph Law
Alfred Shetfield	BSI
Fred Bon	Bon : Asso
JOE LAMIER	NELSON MULLINS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE

(Committee Name)

5-29-13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Emila Sutton	NC HFA
Sabrina Lea	DHHS/DMA
Jason Barbour	Sen. Apodaca
Chuck Stone	SEANC
Tracy Colvard	~~AAAA~~
Eileen Vaillancourt	Alzheimer's Assn.
Samuel Wolfe	MWCLLC
~~W. H. H. H.~~	BCS
Chris McClure	Brooks Pierce
Kay Emanuel	School of Government
Matt Wolfe	PPAB
Dylan Watts	Smith A.
Adam Sholar	DHHS
Kelly Cashie	DHHS-DMA
Kay Pakoy	NASW-NC
Patch Ottom	Criminal Innovations
MARK STELBUM	NCHEA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Margaret Matrone	NCHFA
Charles French	Minority Coalition of Behavioral Health
Arlana Sims	11
Diana Duncan	Minority Coalition of Behavioral Health Providers
Patricia Amend	NCHFA
Lauren Knott	NCHC
Carley Ruff	NCHU
Michael DeKors	HPMS (High Point Medical Society)
Wilma Bailes	HPMS & GGSM
Betty Leake	Aplus National Home Health
Abby Emmanuel	NMBS, NC
Christopher Hunt	NMSS
Andrew Blackburn	SSG NC
BOB KUAB	NCHFA
Julia Adams	The Arc of NC / NCARF
Wick Pany-Hie	NCHFA
Pam Riles	

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
F/AY J. Lep	Minority Coalition HC Behavior
Nimish Bhatt	Minority Coalition HC B.
Nadine McNair-Smith	Minority Coalition HCB
Tyran Lennon	Minority Coalition HCB
Ed Norman	NCDHHS- Div. Public Health
Made & McNeill	Caroline's Health Care
Heley Nicholson	UNC HC
Cory Harbo	NCHA
Tom Friedman	SHH
Kenza Rothman	LCA
James Bond	MIB
Douglas Heaton	WM
Chip Bygones	NIMS
DANIEL VANLIERE	Vidant
Penith Myr	SC
BS Miller	Cove Health
Erica Nelson	NCHA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Charles Marshall	Brooks Pence
Angie Harris	Wood & Smith
Walter Tinslow MD	Physician
C S Hollis	TSS
George Smith	NP
Dean Plumbert	PS
~~DAVID RICE~~	~~WCFPC~~
DAVID RICE	MFS
Walter Tinslow MD	Physician
Walter Tinslow MD	NCDs & NCPTA
Maure Gardner	GSK
Adm Slolan	DHHS
Brian Rabinovitz	AGO
Robert Wern	DHHS
Jessica Keith	DHHS
Doug Miskew	PSG
IAN CROFATER	SOUTHLIGHT / Coal. L

**Senate Committee on Health Care
Wednesday, June 5, 2013, 11:00 AM
544 Legislative Office Building**

AGENDA

Senator Hise, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 543	MHDDSA Providers As Uncompensated Guardians.	Representative Jones Representative Avila Representative Glazier Representative Turner

Adjournment

**Senate Committee on Health Care
Wednesday, June 5, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on June 5, 2013, in Room 544 of the Legislative Office Building. Nine members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise called the meeting to order by recognizing the Pages—Eva Barlow of New Hanover County, Madison Bell of Franklin County, Allison Clark of Wake County, Grayson Russell of Wake County, Anjan Sapasetty of Wake County, Carol Ann Schwarzenbach of Onslow County, and Max Toney of Rockingham County; and the Sergeants-at-Arms—Billy Fritscher, Ed Kesler, Ashley Mickens, Hal Roach, and Steve Wilson.

Senator Hise recognized Senator Randleman to present House Bill 543 – Guardianship Roles of MHDDSA Providers. Senator Randleman moved for adoption of a PCS for House Bill 543. The motion to adopt the PCS passed and Senator Randleman explained the bill. Senator Tucker moved for a favorable report to the PCS, unfavorable to the original bill. The PCS passed.

The meeting adjourned at 11:08 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

Principal Clerk _____
Reading Clerk _____

Corrected #1: HB634 and HB479 have been removed.

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 5, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
HB 543	MHDDSA Providers As Uncompensated Guardians.	Representative Jones Representative Avila Representative Glazier Representative Turner

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, June 05, 2013

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

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

HB 543 (CS#1)

MHDDSA Providers As Uncompensated Guardians.

Draft Number: H543-PCS10420-MG-15

Sequential Referral: Judiciary I

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Shirley Randleman will handle HB 543



* C M R 6 9 8 - V - 2 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

2

HOUSE BILL 543
Committee Substitute Favorable 4/24/13

Short Title: MHDDSA Providers As Uncompensated Guardians.

(Public)

Sponsors:

Referred to:

April 4, 2013

A BILL TO BE ENTITLED

AN ACT ALLOWING PROVIDERS OF MENTAL HEALTH, DEVELOPMENTAL
DISABILITIES, OR SUBSTANCE ABUSE SERVICES TO SERVE AS
UNCOMPENSATED, COURT-APPOINTED GUARDIANS TO UNRELATED
CLIENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 35A-1213(f) reads as rewritten:

"(f) An individual who contracts with or is employed by an entity that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual or entity is providing these services, unless the individual (i) is a parent of that ward. ~~The prohibition provided in this subsection shall not apply to that ward, (ii) is a member of the ward's immediate family who is under contract with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services and is serving as a guardian as of January 1, 2013-2013, or (iii) is not biologically related to the ward and was serving on March 1, 2013, as a guardian without compensation for guardianship services.~~ For the purposes of this subsection, the term "immediate family" is defined as a spouse, child, sibling, parent, grandparent, or grandchild. The term also includes stepparents, stepchildren, stepsiblings, and adoptive relationships."

SECTION 2. The Joint Legislative Oversight Committee on Health and Human Services shall appoint a subcommittee to examine the impact of the 1915(b)/(c) Medicaid waiver and other mental health system reforms on public guardianship services, including guardianship roles, responsibilities and procedures, and the effect on existing relationships between guardians and wards. The subcommittee shall report its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before May 9, 2014, at which time it shall terminate.

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



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

D

HOUSE BILL 543
Committee Substitute Favorable 4/24/13
PROPOSED SENATE COMMITTEE SUBSTITUTE H543-CSMG-15 [v.5]
5/8/2013 2:33:54 PM

Short Title: Guardianship Roles of MHDDSA Providers.

(Public)

Sponsors:

Referred to:

April 4, 2013

A BILL TO BE ENTITLED
AN ACT ADDRESSING PERMISSIBLE GUARDIANSHIP ROLES FOR CORPORATIONS
AND INDIVIDUALS THAT PROVIDE MENTAL HEALTH, DEVELOPMENTAL
DISABILITIES, OR SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 35A-1213(c) reads as rewritten:

"(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency. A corporation shall not be appointed as guardian for any individual to whom it provides mental health, developmental disabilities, or substance abuse services for compensation as part of a contractual or other arrangement with a local management entity (LME), including an LME that has been approved to operate the 1915(b)/(c) Medicaid Waiver."

SECTION 2. G.S. 35A-1213(f) reads as rewritten:

"(f) An individual who contracts with or is employed by an entity that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual or entity is providing these services, unless the individual is ~~a one of the following:~~

(1) A parent of that ward. ~~The prohibition provided in this subsection shall not apply to a~~

(2) A member of the ward's immediate family, a licensed family foster care provider, or a licensed therapeutic foster care provider who is under contract with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services and is serving as a guardian as of January 1, 2013. For the purposes of this subsection, the term "immediate family" is defined as a spouse, child, sibling, parent, grandparent, or grandchild. The term also includes stepparents, stepchildren, stepsiblings, and adoptive relationships.

(3) A biologically unrelated individual who was serving on March 1, 2013, as a guardian without compensation for guardianship services."

SECTION 3. The Joint Legislative Oversight Committee on Health and Human Services shall appoint a subcommittee to examine the impact of the 1915(b)/(c) Medicaid



* H 5 4 3 - C S M G - 1 5 - V - 5 *

1 waiver and other mental health system reforms on public guardianship services, including
2 guardianship roles, responsibilities and procedures, and the effect on existing relationships
3 between guardians and wards. The subcommittee shall report its findings and recommendations
4 to the Joint Legislative Oversight Committee on Health and Human Services on or before May
5 9, 2014, at which time it shall terminate.

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



HOUSE BILL 543: MHDDSA Providers As Uncompensated Guardians

2013-2014 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Judiciary I	Date:	June 4, 2013
Introduced by:	Reps. Jones, Avila, Glazier, Turner	Prepared by:	Theresa Matula Committee Staff
Analysis of:	PCS to Second Edition H543-CSMG-15		

SUMMARY: *The PCS for House Bill 543 amends the qualifications for corporations or individuals appointed as guardians and requires the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to study the impact of the 1915(b)/(c) Medicaid Waiver and other mental health system reforms on public guardianship services.*

CURRENT LAW: Chapter 35A, Article 5, provides for the *appointment of a guardian* for an incompetent person. . G.S. 35A-1210 specifies that any individual, corporation, or disinterested public agent may file with the clerk an application for the appointment of a guardian for an incompetent person. The application must provide the following:

- (1) Name, age, address, and county of residence of the ward or respondent;
- (2) Name, address, and county of residence of the applicant, relationship if any to the respondent or ward, and interest in the proceeding;
- (3) Name, address, and county of residence of the respondent's next of kin and other persons known to have an interest in the proceeding;
- (4) General statement of the ward's or respondent's assets and liabilities with an estimate of the value of any property, including any income and receivables to which he [or she] is entitled; and
- (5) Whether the applicant seeks the appointment of a guardian of the person, a guardian of the estate, or a general guardian, and whom the applicant recommends or seeks to have appointed as such guardian or guardians.

G.S. 35A-1213 establishes the *qualifications of guardians*. G.S. 35A-1213(a) provides that the clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agency. Subsection (b) provides requirements for appointment of a nonresident guardian. Subsection (c) provides requirements of a corporation appointed as a guardian. S.L. 2012-151 amended Subsection (c) to require that a corporation: must meet the requirements outlined in Chapters 55 and 55D; provide a written copy of its charter to the Clerk of superior court; and a corporation contracting with a public agency to serve as a guardian must attend and verify attendance at guardianship training. Subsection (d) pertains to disinterested public agents appointed by the clerk to serve a guardians and potential conflicts of interest. Subsection (e) generally prohibits an employee of a treatment facility from serving as a guardian for a ward who in an inpatient in or resident of a facility where the employee works. S.L. 2012-151 added subsection (f) which prohibits an individual who contracts with or is employed by an entity that contracts with an LME for the delivery of mental health, developmental disabilities, and substance abuse services, from serving as a guardian for a ward for whom the individual or entity is providing services, unless they are a member of the ward's immediate family under contract with the LME and serving as a guardian as of January 1, 2013.



House PCS 543

Page 2

Chapter 55 is the North Carolina Business Corporation Act. §55-1-40 (4) establishes that a "**Corporation**" or "**domestic corporation**" means a corporation for profit or a corporation having capital stock that is incorporated under or subject to the provisions of this Chapter and that is not a foreign corporation except that in G.S. 55-9-01 and G.S. 55-15-21 "corporation" includes domestic and foreign corporations. **Chapter 55D** pertains to Filings, Names, and Registered Agents for Corporations, Nonprofit Corporations and Partnerships. §55D-1(1) provides that "Corporation" or "domestic corporation" is defined in G.S. 55-1-40(4).

BILL ANALYSIS:

Section 1 of the PCS for HB 543 amends G.S. 35A-1213(c) to prohibit a corporation from being appointed as a guardian for any individual to whom it provides mental health, developmental disabilities, or substance abuse services for compensation as part of a contract or other arrangement with a local management entity (LME). The term "LME" includes an LME approved to operate the 1915(b)/(c) Medicaid Waiver.

Section 2 of the PCS amends G.S. 35A-1213(f) which prohibits individuals who contract with, or are employed by an entity that contracts with, an LME for the delivery of mental health, developmental disabilities and substance abuse (MH/DD/SA) services, from serving as a guardian for a ward for whom the individual or entity is providing these services except in certain situations. The PCS enumerates and amends the exceptions. The exceptions are as follows:

- The individual is a parent of the ward.
- The individual is a member of the ward's immediate family, a licensed family foster care provider, or a licensed therapeutic foster care provider who is under contract with a LME for the delivery of MH/DD/SA services and is serving as a guardian as of January 1, 2013. "Immediate family" is defined as a spouse, child, sibling, parent, grandparent, or grandchild, including stepparents, stepchildren, stepsiblings, and adoptive relationships.
- The individual is biologically unrelated and was serving on March 1, 2013, as a guardian without compensation for guardianship services.

Section 3 requires the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to examine the impact of the 1915(b)/(c) Medicaid Waiver and other mental health system reforms on public guardianship services, including guardianship roles, responsibilities and procedures, and the effect on existing relationships between guardians and wards. The subcommittee is required to report findings and recommendations to the Committee on or before May 9, 2014, and then the subcommittee will terminate.

EFFECTIVE DATE: House Bill 543 would become effective when it becomes law.

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: ~~6-5~~ TIME: 11 AM

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

Page	Name	Hometown	Sponsoring Senator
1.	Madison Bell	Louisburg	Barfoot
2.	~~Grayson Russell~~ Grayson Russell	Knightdale	Berger
3.	Carol Ann Schwarzenbach	Jacksonville	Brown
4.	Eva Barlowe	Wilmington	Sackson
5.	Allison Clark	Raleigh	Berger
6.	Max Toney	Reidsville	Berger
7.	Anjan ~~ANJAN~~ SAPASEITY	CART	JACKSON
8.	~~ANJAN~~		
9.			
10.			

Do not add names below the grid.

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

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

June 5th 2013

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Erleen Raynor MD	NCMS/NEOHNS
Will Barnett	NCMS
Chris Sigmann	inter - sp. kind
Karen Boller	LCA
Sansana Davis	WM
Melissa Tink	NCAAC
Dylan Watt	Smith A
Melinda White	Newton Family Phys/NCMGM
Debbie Cashion	Catawba Pediatrics/NCMGM
Adam Sholar	DHHS
George Smith	NP
Deb Good	DMA

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

6-5-2013

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Betty Doster	UNC Charlotte
Andy Chase	KMA
Sarah Wolfe	MWC LLC
Kay Emanuel	School of Government
Betsy Vetter	American Heart Assn
Steve L Herring	349 Weaver Rd Hillsboro NC
Christine Craig	WakeMed

Senate Committee on Health Care
Wednesday, June 19, 2013, 11:00 a.m.
544

AGENDA

Senator Louis Pate, Presiding

Welcome and Opening Remarks

Introduction of Pages and Sgts.-at-Arms

Bills:

BILL NO.	SHORT TITLE	SPONSOR
HB 467	Breast Density Notification & Awareness	Representative Faircloth Representative Adams Representative Harrison Representative Fulghum
HB 832	Expand Pharmacists' Immunizing Authority	Representative Avila Representative Lewis Representative Foushee Representative Glazier
HB 371	Chiropractic Assistant Certification/Fee A-B	Representative Bryan Representative Conrad
HB 830	Adopt State Symbols	Representative Avila Representative S. Martin Representative McElraft Representative West

Other Business

Adjournment

**Senate Committee on Health Care
Wednesday, June 19, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on June 19, 2013 in Room 544 of the Legislative Office Building. Fifteen members were present.

Senator Louis Pate presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Billy Fritscher, Ed Kesler, Ashley Mickens and Steve Wilson. He then recognized the Pages: Emma Nance and Allyson Yelton of Rutherfordton, J. C. Barringer of Cary, Jake Barton of Stells, Gordon Ma of Cary, TyVan deZande of Raleigh, Parker Lee of Fuquay Varina, and Tarik Zikvy of Chapel Hill.

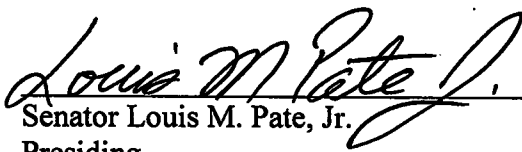
Senator Pate recognized Senator Robinson and Representative Faircloth to explain HB 467 "Breast Density Notification & Awareness." A PCS was offered and Senator Parmon moved to accept the PCS. After the bill had been explained, several members of the audience spoke in support of the bill. They included: Dr. Margaret Bertrand, Radiologist from Greensboro, Dr. Bruce Schroder, Radiologist of Greenville, Gina Waters and Addy Jeffrey - both breast cancer survivors. After a brief question and answer session, Senator Parmon moved for a favorable report of the PCS, unfavorable to the original bill. Motion carried.

A PCS for HB 832 "Expand Pharmacists' Immunizing Authority" was next on the agenda to be brought before the committee. Senator Robinson moved to accept the PCS. Representative Avila explained the bill, after which Senator Rabin moved for a favorable report to the PCS, unfavorable to the original. Motion carried.

Representative Bryan was called on to explain the next bill, HB 371 "Chiropractic Assistant Certification/Fee.AB. Senator Hise moved for a favorable report; motion carried.

Representative Martin was recognized to explain HB 830 "Adopt State Symbols." Senator McKissick moved for a favorable report; the motion carried.

The meeting adjourned at 11:50 a.m.



Senator Louis M. Pate, Jr.
Presiding



Edna Pearce, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
it: Tuesday, June 18, 2013 04:30 PM
To: Rep. Rick Glazier; Rep. David Lewis; Rep. Marilyn Avila; Rep. Valerie Foushee; Rep. Debra Conrad; Rep. Rob Bryan; Rep. Alma Adams; Rep. Pricey Harrison; Rep. John Faircloth; Rep. Jim Fulghum; Rep. Roger West; Rep. Pat McElraft; Rep. Susan Martin; Rep. Craig Horn; Rep. William Brisson; Rep. Mark Hollo
Cc: Carin Savel (Rep. Rick Glazier); Grace Rogers (Rep. David Lewis); Ted Fitzgerald (Rep. David Lewis); Susan Lewis (Rep. Marilyn Avila); James Spivey (Rep. Valerie Foushee); Rachel Delk (Rep. Debra Conrad); Michael Ludwig (Rep. Rob Bryan); Sandra Brown (Rep. Alma Adams); Sue Osborne (Rep. Pricey Harrison); Becky Bauerband (Rep. John Faircloth); Emily Roberson (Rep. Jim Fulghum); Linda C. Johnson (Rep. Roger West); Nancy Fox (Rep. Pat McElraft); Anne Harvey Smith (Rep. Susan Martin); Steven Franklin (Rep. Craig Horn); Caroline Stirling (Rep. William Brisson); Carol Wakely (Rep. Mark Hollo)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wednesday, June 19, 2013 at 11:00 AM - CORRECTED #2

Principal Clerk _____
Reading Clerk _____

Corrected #2: HB 173 has been removed from the agenda.

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 19, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
HB 832	Expand Pharmacists' Immunizing Authority.	Representative Avila Representative Lewis Representative Foushee Representative Glazier
HB 371	Chiropractic Assistant Certification/Fee.-AB	Representative Bryan Representative Conrad
HB 467	Breast Density Notification &	Representative Faircloth

Awareness.

HB 830

Adopt State Symbols.

Representative Adams
Representative Harrison
Representative Fulghum
Representative Avila
Representative S. Martin
Representative McElraft
Representative West

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, June 19, 2013.

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

FAVORABLE

HB 371 Chiropractic Assistant Certification/Fee.-AB
Draft Number: None
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

HB 830 (CS#1) Adopt State Symbols.
Draft Number: None
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

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

HB 467 (CS#1) Breast Density Notification & Awareness.
Draft Number: H467-PCS30575-SH-21
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

HB 832 (CS#1) Expand Pharmacists Immunizing Authority.
Draft Number: H832-PCS80389-RF-27
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 4

Senator Ralph Hise will handle HB 371
Senator E.S. Newton will handle HB 830
Senator Gladys Robinson will handle HB 467
Senator Trudy Wade will handle HB 832



* C M R 7 6 8 - V - 1 *

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

2

HOUSE BILL 467
Committee Substitute Favorable 4/9/13

Short Title: Breast Density Notification & Awareness.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED

AN ACT REQUIRING HEALTH CARE FACILITIES THAT PERFORM
MAMMOGRAPHY EXAMINATIONS TO COMMUNICATE MAMMOGRAPHIC
BREAST DENSITY INFORMATION TO PATIENTS AND TO MAKE A
CORRECTION TO A STATUTE INVOLVING THE CANCER REGISTRY.

Whereas, there are four levels of breast density and the only way to identify breast
density is through a mammography examination; and

Whereas, women classified in the highest two levels have heterogeneously or
extremely dense breast tissue and could have abnormalities that are not easily visible on a
mammogram; and

Whereas, dense breast tissue may also increase the risk of developing cancer; and

Whereas, knowing her individual breast density level will aid in helping a woman
better understand that supplemental screening may be beneficial if she is classified in the two
highest levels of breast density; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 130A of the General Statutes is amended by
adding a new section to read:

"§ 130A-215.5. Communication of mammographic breast density information to patients.

**All health care facilities that perform mammography procedures shall do both of the
following:**

- (1) Include in the summary of the mammography report, required under federal law to be provided to a patient, information that identifies the patient's individual breast density level based upon the Breast Imaging Reporting and Data System established by the American College of Radiology. If the facility determines that a patient has heterogeneously or extremely dense breasts, the summary of the mammography report shall include the following notice, "Your mammogram indicates that you have dense breast tissue. Dense breast tissue is a relatively common condition. Although common, both cancerous and noncancerous abnormalities may be more difficult to distinguish against a background of dense breast tissue. Dense breast tissue may be associated with an increased risk of breast cancer and you may benefit from supplemental screening tests as recommended by your physician. We are also providing this information to raise your awareness of the importance of breast self-examination and of speaking to your physician about all risk factors."



(2) Provide all patients who receive diagnostic or screening mammograms with informative material about breast density. This informative material may include the American College of Radiology's most current brochure on the subject of breast density."

SECTION 2. G.S. 130A-211 reads as rewritten:

"§ 130A-211. Immunity of persons who report cancer.

A person who makes a report pursuant to G.S. 130A-209 ~~or 130A-210~~ to the central cancer registry shall be immune from any civil or criminal liability that might otherwise be incurred or imposed."

SECTION 3. The Medical Care Commission shall adopt rules requiring adherence to G.S. 130A-215.5 as a condition of receiving state certification for all facilities performing mammography procedures.

SECTION 4. This act becomes effective October 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

D

HOUSE BILL 467
Committee Substitute Favorable 4/9/13
PROPOSED SENATE COMMITTEE SUBSTITUTE H467-CSSH-21 [v.2]
6/12/2013 3:11:06 PM

Short Title: Breast Density Notification & Awareness.

(Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED

AN ACT REQUIRING HEALTH CARE FACILITIES THAT PERFORM
MAMMOGRAPHY EXAMINATIONS TO COMMUNICATE MAMMOGRAPHIC
BREAST DENSITY INFORMATION TO PATIENTS AND TO MAKE A
CORRECTION TO A STATUTE INVOLVING THE CANCER REGISTRY.

Whereas, mammographic examinations are typically used to characterize breast
density into one of four groups; and

Whereas, women classified in the highest two levels have heterogeneously or
extremely dense breast tissue and could have abnormalities that are not easily visible on a
mammogram; and

Whereas, dense breast tissue may also increase the risk of developing cancer; and

Whereas, knowing her individual breast density level may aid in helping a woman
better understand that supplemental screening may be beneficial if she is classified in the two
highest levels of breast density; Now, therefore,
The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 130A of the General Statutes is amended by
adding a new section to read:

"§ 130A-215.5. Communication of mammographic breast density information to patients.

(a) All health care facilities that perform mammography examinations shall include in the summary of the mammography report, required by federal law to be provided to a patient, information that identifies the patient's individual breast density classification based on the Breast Imaging Reporting and Data System established by the American College of Radiology. If the facility determines that a patient has heterogeneously or extremely dense breasts, the summary of the mammography report shall include the following notice:

"Your mammogram indicates that you may have dense breast tissue. Dense breast tissue is relatively common and is found in more than forty percent (40%) of women. The presence of dense tissue may make it more difficult to detect abnormalities in the breast and may be associated with an increased risk of breast cancer. We are providing this information to raise your awareness of this important factor and to encourage you to talk with your physician about this and other breast cancer risk factors. Together, you can decide which screening options are right for you. A report of your results was sent to your physician."

(b) Patients who receive diagnostic or screening mammograms may be directed to informative material about breast density. This informative material may include the American College of Radiology's most current brochure on the subject of breast density."

SECTION 2. G.S. 130A-211 reads as rewritten:



1 **"§ 130A-211. Immunity of persons who report cancer.**

2 A person who makes a report pursuant to G.S. 130A-209 ~~or 130A-210~~ to the central cancer
3 registry shall be immune from any civil or criminal liability that might otherwise be incurred or
4 imposed."

5 **SECTION 3.** This act becomes effective January 1, 2014.



HOUSE BILL 467: Breast Density Notification & Awareness

2013-2014 General Assembly

Committee:	Senate Health Care	Date:	June 18, 2013
Introduced by:	Reps. Faircloth, Adams, Harrison, Fulghum	Prepared by:	Theresa Matula
Analysis of:	PCS to Second Edition		Committee Staff
	H467-CSSH-21		

SUMMARY: *The Proposed Committee Substitute (PCS) for HB 467 requires all health care facilities performing mammography examinations to include information in the mammography report that identifies the patient's individual breast density classification. If the facility determines that a patient has heterogeneously or extremely dense breasts they must also include a specific notice. Health care facilities may also direct patients to informative material about breast density. Section 2 contains a technical correction deleting a statutory citation that no longer exists.*

BACKGROUND:

(The following information is from the American College of Radiology.)

What is breast density? Breasts are made up of a mixture of fibrous and glandular tissue and fatty tissue. Breasts are considered dense if they have a lot of fibrous or glandular tissue but not much fat. Density may decrease with age, but there is little, if any, change in most women.

Why is breast density important? Having dense breast tissue may increase the risk of getting breast cancer. Dense breasts also make it more difficult for doctors to spot cancer on mammograms. Dense tissue appears white on a mammogram. Lumps, both benign and cancerous, also appear white. So, mammograms can be less accurate in women with dense breasts.

How does someone know if they have dense breasts? Breast density is determined by the radiologist who reads the mammogram. There are four categories of mammographic density. The radiologist assigns each mammogram to one of the categories.

Breast Density Occurrence in the US: Extremely dense breasts - 10%; Heterogeneously dense breasts - 40%; Scattered areas of fibroglandular density in breasts - 40%; Almost entirely fatty breasts - 10%.

Additional Information: <http://www.acr.org/News-Publications/~media/180321AF51AF4EA38FEC091461F5B695.pdf>

BILL ANALYSIS:

Section 1 of HB 467 establishes a new section (G.S. 130A-215.5) in Article 7 (Chronic Disease; Part1. Cancer) of Chapter 130A (Public Health) regarding communication of mammographic breast density information to patients.

Subsection (a) requires all health care facilities performing mammography examinations to include information that identifies the patient's individual breast density classification in the required mammography report. The breast density classification will be based on the Breast Imaging Reporting and Data System established by the American College of Radiology.

For patients with heterogeneously or extremely dense breasts, the mammography report must include the following notice:

O. Walker Reagan
Director



Research Division
(919) 733-2578

Your mammogram indicates that you may have dense breast tissue. Dense breast tissue is relatively common and is found in more than forty percent (40%) of women. The presence of dense tissue may make it more difficult to detect abnormalities in the breast and may be associated with an increased risk of breast cancer. We are providing this information to raise your awareness of this important factor and to encourage you to talk with your physician about this and other breast cancer risk factors. Together, you can decide which screening options are right for you. A report of your results was sent to your physician.

The PCS makes changes to the wording of the notice.

Subsection (b) of the PCS specifies that patients receiving diagnostic or screening mammograms may be directed to informative material about breast density, including a current brochure on breast density by the American College of Radiology. (The current version of the bill requires health care facilities to provide informative material about breast density.)

Section 2 makes a technical change deleting an obsolete statutory reference contained in G.S. 130A-211 which pertains to the immunity of persons who report cancer.

EFFECTIVE DATE:

The PCS provides that the bill would become effective January 1, 2014. (The effective date contained in the current bill is October 1, 2013.)

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

D

HOUSE BILL 832*
Committee Substitute Favorable 5/9/13
Third Edition Engrossed 5/13/13
PROPOSED SENATE COMMITTEE SUBSTITUTE H832-CSRF-27 [v.5]
6/18/2013 3:02:47 PM

Short Title: Expand Pharmacists' Immunizing Authority.

(Public)

Sponsors:

Referred to:

April 11, 2013

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:

"(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.

(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) Has notified the North Carolina Board of Pharmacy and the North Carolina
Medical Board of immunizing pharmacist status.

(6) 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
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~~



* H 8 3 2 - C S R F - 2 7 - V - 5 *

~~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 is authorized and permitted to administer drugs as provided in G.S. 90-85.15B, and in accordance with rules adopted by each of the Board of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. These 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) Except as provided in subsection (b) and (c) of this section, an immunizing pharmacist may administer vaccinations or immunizations only if the vaccinations or immunizations are recommended or required by the Centers for Disease Control and Prevention and administered to persons at least 18 years of age pursuant to a specific prescription order.

(b) An immunizing pharmacist may administer the vaccinations or immunizations listed in subdivisions (1) through (5) of this subsection to persons at least 18 years of age if the vaccinations or immunizations are administered under written protocols as defined in 21 NCAC 46 .2507(b)(12) and 21 NCAC 32U .0101(b)(12) and in accordance with the supervising physician's responsibilities as defined in 21 NCAC 46 .2507(e) and 21 NCAC 32U .0101(e), and the physician is licensed in and has a practice physically located in North Carolina:

(1) Pneumococcal polysaccharide or pneumococcal conjugate vaccines.

(2) Herpes zoster vaccine.

(3) Hepatitis B vaccine.

(4) Meningococcal polysaccharide or meningococcal conjugate vaccines.

(5) Tetanus-diphtheria, tetanus and diphtheria toxoids and pertussis, tetanus and diphtheria toxoids and acellular pertussis, or tetanus toxoid vaccines. However, a pharmacist shall not administer any of these vaccines if the patient discloses that the patient has an open wound, puncture, or tissue tear.

(c) An immunizing pharmacist may administer the influenza vaccine to persons at least 14 years of age pursuant to 21 NCAC 46 .2507 and 21 NCAC 32U .0101.

(d) 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) Within 72 hours after administration of the vaccine or immunization, notify any primary care provider identified by the patient. If the patient does not identify a primary care provider, the immunizing pharmacist shall direct the patient to information describing the benefits to a patient of having a primary care physician, prepared by any of the following: North Carolina Medical Board, North Carolina Academy of Family Physicians, North Carolina Medical Society, or Community Care of North Carolina.

(3) Except for influenza vaccines administered under G.S. 90-85.15B(b)(6), 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 72 hours after the administration. In the event the registry is not operable, an immunizing pharmacist shall report as soon as reasonably possible. "

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

"§ 130A-153. Obtaining immunization; reporting by local health departments; access to immunization information in patient records; immunization of minors.

(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or medicine~~, from a local health department, ~~department~~, or in the case of a person at least 18 years of age, from an immunizing pharmacist. 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, an 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.

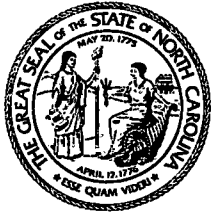
(d) A physician or local health department may immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A physician or local health department may also immunize a minor who is presented for immunization by an adult who signs a statement that he or she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

SECTION 6. Representatives of the North Carolina Academy of Family Physicians, the North Carolina Medical Society, the North Carolina Pediatric Society, the North Carolina Association of Community Pharmacists, the North Carolina Association of Pharmacists, and the North Carolina Retail Merchants Association are directed to cooperate and collaborate to recommend a minimum standard screening questionnaire and safety procedures for written protocols for vaccinations or immunizations administered under G.S. 90-85.15B(b). The questionnaire and recommended standards shall be submitted to the North Carolina Board of Medicine, the North Carolina Board of Nursing, the North Carolina

1 Board of Pharmacy, and the Joint Legislative Oversight Committee on Health and Human
2 Services no later than October 1, 2013. In the event agreement is not reached on a minimum
3 standard screening questionnaire and safety procedures for written protocols by October 1,
4 2013, the Immunization Branch of the North Carolina Division of Public Health shall develop
5 the questionnaire and standards and submit them to the North Carolina Board of Medicine, the
6 North Carolina Board of Nursing, the North Carolina Board of Pharmacy, and the Joint
7 Legislative Oversight Committee on Health and Human Services by January 1, 2014.

8 **SECTION 7.** Notwithstanding the provisions of Sections 1 through 5 of this act,
9 pharmacists who were qualified to administer influenza, pneumococcal, and zoster vaccines
10 prior to the effective date of this act may continue to administer these vaccines in accordance
11 with the provisions of 21 NCAC 46 .2507 until June 30, 2014. Notwithstanding the provisions
12 of Sections 1 through 5 of this act, 21 NCAC 46 .2507(c)(5), 21 NCAC 32U .0101(c)(5), or any
13 other provision of law, pharmacists who were qualified to administer influenza, pneumococcal,
14 and zoster vaccines prior to the effective date of this act may administer the influenza vaccine
15 to persons at least 14 years old in accordance with the provisions of 21 NCAC 46 .2507 until
16 June 30, 2014.

17 **SECTION 8.** Sections 1 through 5 of this act become effective October 1, 2013.
18 The remainder of this act is effective when it becomes law.



HOUSE BILL 832: Expand Pharmacists' Immunizing Authority

2013-2014 General Assembly

Committee:	Senate Health Care	Date:	June 10, 2013
Introduced by:	Reps. Avila, Lewis, Foushee, Glazier	Prepared by:	Barbara Riley
Analysis of:	PCS to Third Edition H832-CSRF-27		Committee Counsel

SUMMARY: *House Bill 832 would create a new section of the Pharmacy Practice Act authorizing a pharmacist to administer to adult vaccines or immunizations recommended or required by the Centers for Disease Control and Prevention ("CDC"), and to administer other enumerated vaccinations or immunizations. The proposed committee substitute (1) requires that the administration of drugs by an immunizing pharmacist shall be in accordance with rules adopted by each of the Boards of Pharmacy and Nursing, and the NC Medical Board, (2) provides that an immunizing pharmacist may administer a flu vaccine to persons at least 14 years old, and (3) changes the effective date of the act.*

[As introduced, this bill was identical to S500, as introduced by Sen. Hartsell, which is currently in Rules and Operations of the Senate.]

BILL ANALYSIS:

Section 1 creates G.S. 90-85.3(i1), a definition of "Immunizing pharmacist," in the Pharmacy Practice Act, and specifies the mandatory training, education and certification requirements.

Section 2 deletes the current description of the "practice of pharmacy" from G.S. 90-85.3(r) and provides that the definition is set out in G.S. 90-85.3A.

Section 3 describes the "practice of pharmacy" in a new G.S. 90-85.3A. The definition includes permitting an immunizing pharmacist to administer drugs in accordance with the provisions established in Section 4 of the bill. The PCS provides that the immunizing pharmacist must act in accordance with rules adopted by each of the Board of Pharmacy, the Board of Nursing, and the NC Medical Board designed to protect the health and safety of patients.

Section 4 creates a new G.S. 90-85.15B that would authorize an immunizing pharmacist to administer only vaccines or immunizations recommended or required by the CDC and prescribed for persons at least 18 years old. The section enumerates the vaccinations that an immunizing pharmacist may administer under written protocols and in accordance with regulations imposed on licensed physicians who are licensed and who practice in the State. An immunizing pharmacist must maintain a record of vaccines or immunizations administered to a patient and, within 72 hours, to notify the patient's primary care provider that the vaccine was administered or, if the patient does not have a primary care physician, to advise the patient of the benefits of having one. Finally, the bill would require an immunizing pharmacist to access the North Carolina Immunization Registry before administering any vaccine except for influenza, and to record the vaccination or immunization in the Registry within 72 hours of administration. The PCS authorizes an immunizing pharmacist to administer a flu vaccine to persons at least 14 years old and provides that if the NC Immunization Registry is not operable, the immunizing pharmacist shall report as soon as reasonably possible.



House PCS 832

Page 2

Section 5 makes conforming changes to the Chapter 103A of the General Statutes relating to immunizations under the Public Health Law.

Section 6 directs specified organizations to collaborate to recommend a screening questionnaire and safety procedures for written protocols for vaccines administered by an immunizing pharmacist. If the named organizations are unable to reach agreement, the Division of Public Health is directed to develop the questionnaire and protocols.

Section 7 allows pharmacists currently qualified to administer influenza, pneumococcal, and zoster vaccines to continue to do so under existing rules until June 30, 2014. In addition, pharmacist currently qualified to administer vaccines may administer the flu vaccine to persons at least 14 years old until June 30, 2014.

EFFECTIVE DATE: Sections 1 through 5 of the act become effective October 1, 2013. The remainder of the act is effective when it becomes law.

Jan Paul, counsel to House Health, substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

1

HOUSE BILL 832*

Short Title: Expand Pharmacists' Immunizing Authority. (Public)

Sponsors: Representatives Avila, Lewis, Foushee, and Glazier (Primary Sponsors).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Health and Human Services, if favorable, Commerce and Job Development.

April 11, 2013

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:

"(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.
- (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) Has notified the North Carolina Board of Pharmacy and the North Carolina Medical Board of immunizing pharmacist status.
- (6) 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 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~~



* H 8 3 2 - V - 1 *

~~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 is authorized and permitted to administer drugs as provided in G.S. 90-85.15B.

(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) Except as provided in subsection (b) of this section, an immunizing pharmacist shall only administer vaccines or immunizations recommended or required by the Centers for Disease Control and Prevention to persons at least 18 years of age pursuant to a specific prescription order.

(b) An immunizing pharmacist may administer the following vaccinations or immunizations pursuant to a standing order or protocols developed with and overseen by a physician licensed in and whose practice is physically located in North Carolina:

(1) Pneumococcal polysaccharide or pneumococcal conjugate vaccines.

(2) Herpes zoster vaccine.

(3) Hepatitis B vaccine.

(4) Meningococcal polysaccharide or meningococcal conjugate vaccines.

(5) Tetanus-diphtheria, tetanus and diphtheria toxoids and pertussis, tetanus and diphtheria toxoids and acellular pertussis, or tetanus toxoid vaccines.

(6) Influenza vaccine pursuant to 21 NCAC 46 .2507 and 21 NCAC 32U .101, which may be administered to patients aged 14 years and older.

(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) Notify within 72 hours after administration the patient's primary care provider, if the patient has identified a primary care provider, and either the prescribing physician or the physician who issued the standing order or protocol. If the patient does not have a primary care provider, the immunizing pharmacist shall direct the patient to information describing the

benefits to a patient of having a primary care physician, prepared by any of the following: North Carolina Medical Board, North Carolina Academy of Family Physicians, North Carolina Medical Society, or Community Care of North Carolina.

(3) Except for influenza administered pursuant to G.S. 90-85.15B(b)(6), 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 72 hours after the administration."

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

"§ 130A-153. **Obtaining immunization; reporting by local health departments; access to immunization information in patient records; immunization of minors.**

(a) The required immunization may be obtained from a physician licensed to practice ~~medicine or medicine~~, from a local health department, or in the case of a person at least 18 years of age, from an immunizing pharmacist. 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, an 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 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 or local health department may also immunize a minor who is presented for immunization by an adult who signs a statement that he or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to obtain the immunization for the minor."

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

"(a) ~~A physician or physician, immunizing pharmacist acting pursuant to G.S. 90-85.15B, or~~ local health department administering a required vaccine shall give a certificate of immunization to the person who presented the child for immunization. The certificate shall state the name of the child, the name of the child's parent, guardian, or person responsible for the child obtaining the required immunization, the address of the child and the parent, guardian or responsible person, the date of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the doses were given, the name and address of the ~~physician or physician, immunizing pharmacist, or~~ local health department administering the required immunization and other relevant information required by the Commission."

SECTION 7. 21 NCAC 46 .2507 shall govern the administration of influenza, pneumococcal, and zoster vaccines by an immunizing pharmacist; provided, however, an immunizing pharmacist shall be granted the authority to administer influenza vaccine to patients aged 14 years and older. Acting in cooperation with the North Carolina Board of Pharmacy, the North Carolina Medical Board shall similarly amend 21 NCAC 32U .101 to grant immunizing pharmacists the authority to administer influenza vaccine to patients aged 14 years and older.

SECTION 8. This act becomes effective July 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

1

HOUSE BILL 371

Short Title: Chiropractic Assistant Certification/Fee.-AB

(Public)

Sponsors: Representatives Bryan and Conrad (Primary Sponsors).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Regulatory Reform, if favorable, Finance, if favorable, Appropriations.

March 21, 2013

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE STATE BOARD OF CHIROPRACTIC EXAMINERS TO
ESTABLISH AND ENFORCE EDUCATIONAL STANDARDS FOR CHIROPRACTIC
CLINICAL ASSISTANTS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 8 of Chapter 90 of the General Statutes is amended by adding
the following new section to read:**"§ 90-143.4. Chiropractic clinical assistants; certification of competency.**

(a) "Chiropractic clinical assistant" means a nonlicensed employee of a chiropractic physician whose duties include (i) collecting general health data, such as the taking of an oral history or vital sign measurements, (ii) applying therapeutic procedures, such as thermal, sound, light and electrical modalities, and hydrotherapy, and (iii) monitoring prescribed rehabilitative activities. Nothing in this section shall be construed to allow a chiropractic clinical assistant to provide a chiropractic adjustment, manual therapy, nutritional instruction, counseling, or any other therapeutic service that requires individual licensure.

(b) Any person employed as a chiropractic clinical assistant shall obtain a certificate of competency from the State Board of Chiropractic Examiners (Board) within 120 days after the person begins employment. Certification shall not be required for employees whose duties are limited to administrative activities of a nonclinical nature. Except as otherwise provided in this section, it shall be unlawful for any person to practice as a chiropractic clinical assistant unless duly certified by the Board.

(c) An applicant for certification under this section shall be (i) at least 18 years of age, (ii) a high school graduate or the equivalent, (iii) of good moral character, and (iv) able to demonstrate proficiency in the following subjects:

- (1) Basic anatomy.
- (2) Chiropractic philosophy and terminology.
- (3) Utilization of standard therapeutic modalities.
- (4) Contraindications and response to emergencies.
- (5) Jurisprudence and patient privacy protection.

(d) If an applicant for certification is already certified or registered as a chiropractic clinical assistant in another state, the Board shall issue a certificate of competency upon evidence that the applicant is in good standing in the other state, provided the requirements for certification or registration in the other state are substantially similar to or more stringent than the requirements for certification in this State.

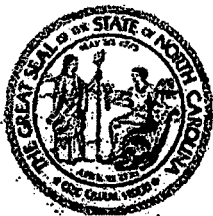


* H 3 7 1 - V - 1 *

1 (e) Any certificate issued under this section shall expire at the end of the calendar year
2 unless renewed in a time and manner established by the Board. Applicants for initial
3 certification or renewal of certification shall pay to the secretary of the Board a fee as
4 prescribed and set by the Board, which fee shall not exceed fifty dollars (\$50.00).

5 (f) The Board may adopt rules pertaining to initial educational requirements, course
6 approval, instructor credentials, examination of applicants, grandfathering, reciprocity,
7 continuing education requirements, and the submission and processing of applications as are
8 reasonably necessary to enforce this section."

9 **SECTION 2.** This act becomes effective July 1, 2014.



HOUSE BILL 371: Chiropractic Assistant Certification/Fee.-AB

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Reps. Bryan, Conrad
Analysis of: First Edition

Date: June 18, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *House Bill 371 amends the Chiropractic Practice Act to authorize the State Board of Chiropractic Examiners to certify chiropractic clinical assistants.*

BILL ANALYSIS:

House Bill 371 adds a new section to the Chiropractic Practice Act (contained in Article 8, Chapter 90) authorizing the Board of Chiropractic Examiners to certify chiropractic clinical assistants. A chiropractic clinical assistant is defined as a non-licensed employee of a chiropractic physician whose duties include the following:

- Collecting general health data.
- Applying limited therapeutic procedures.
- Monitoring prescribed rehabilitative activities.

A chiropractic clinical assistant may not perform any services that require licensure under the Act.

A person employed as a chiropractic clinical assistant must obtain a certificate of competency within 120 days after beginning employment. An applicant for certification must be

- (i) at least 18 years of age,
- (ii) a high school graduate,
- (iii) of good moral character, and
- (iv) able to demonstrate proficiency in number of specified subject areas.

The Board is authorized to issue a certificate of competency to an applicant who is certified or registered in another state, upon a showing that the applicant is in good standing in the other state and that the requirements for certification in the other state are substantially similar to or more stringent than the requirements in this State.

Certificates expire at the end of the calendar year unless renewed in accordance with rules adopted by the Board. The Board may charge a fee for initial applicants and for renewals not to exceed \$50.

The Board is also authorized to adopt rules relating to educational requirements, course approval, instructor credentials, examinations, grandfathering, reciprocity, continuing education, and the submission and processing of applications.

EFFECTIVE DATE: This act becomes effective July 1, 2014.

Heather Fennell, council to House Finance, and Karen Cochrane-Brown, council to House Regulatory Reform, substantially contributed to this summary.

O. Walker Reagan
Director



Research Division
(919) 733-2578

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

H

1

HOUSE BILL 830

Short Title: Adopt State Symbols.

(Public)

Sponsors: Representatives Avila, Martin, McElraft, and West (Primary Sponsors).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Rules, Calendar, and Operations of the House.

April 11, 2013

A BILL TO BE ENTITLED
AN ACT TO ADOPT AN OFFICIAL STATE FOSSIL, FROG, SALAMANDER,
MARSUPIAL, AND FOLK ART.

Whereas, some of North Carolina's official State symbols have been suggested by the State's school children after they have had history, science, social studies, or geography lessons related to North Carolina; and

Whereas, this year some of the suggestions range from the adoption of an official fossil to an official frog; and

Whereas, the State of North Carolina has a number of unique official symbols but does not have an official fossil, frog, salamander, marsupial, or folk art; and

Whereas, the megalodon shark is an extinct shark species that lived over 1.5 million years ago; and

Whereas, the megalodon shark may have reached over 40 feet in length and weighed up to 100 tons; and

Whereas, the megalodon shark had serrated, heart-shaped teeth that may have grown to over seven inches in length; and

Whereas, fossilized teeth of the megalodon shark have been found in North Carolina and throughout the world; and

Whereas, North Carolina and the Southeast region of the United States lead the world in amphibian diversity; and

Whereas, the pine barrens tree frog can be found in the Sandhills and Coastal Plain regions of North Carolina; and

Whereas, the pine barrens tree frog has been considered one of the most striking and beautiful frogs in the Southeast region of the United States; and

Whereas, the pine barrens tree frog by name reflects one of North Carolina's signature trees and ecosystems that have been a vital part of the State's economic, cultural, and natural history since colonial times; and

Whereas, North Carolina also leads the nation and world in salamander diversity, most notably in our Appalachian Mountains; and

Whereas, the marbled salamander is found throughout the State and is unique in that it is a charismatic, striking, chunky-bodied, fossorial amphibian, of which no two are exactly alike in color pattern; and



* H 8 3 0 - V - 1 *

Whereas, according the North Carolina Wildlife Commission's 2005 North Carolina Wildlife Action Plan, the pine barrens tree frog and the marbled salamander have been identified as priority species for population monitoring and conservation in North Carolina; and

Whereas, the Virginia opossum is native to North Carolina and is the only marsupial found in North America; the female carries its underdeveloped young in a pouch until they are capable of living independently, similar to a kangaroo; and

Whereas, the Virginia opossum is one of the oldest and most primitive species of mammal found in North America; and

Whereas, the opossum is about the size of a large house cat with a triangular head; a long pointed nose; dark eyes; a long, scaly, prehensile tail; and short, black, leathery ears; and

Whereas, the Virginia opossum is nocturnal and lives in a wide variety of habitats, including deciduous forests, open woods, and farmland but prefers wet areas such as marshes, swamps, and streams; and

Whereas, at age 65, Vollis Simpson, a self-taught folk artist, began making giant windmills known as "whirligigs" at his home in Wilson, North Carolina; and

Whereas, Mr. Simpson's whirligigs have been exhibited at the North Carolina Museum of Art in Raleigh, the High Museum of Art in Atlanta, Georgia, and the Visionary Art Museum in Baltimore, Maryland, and at other locations, including New York, California, Canada, and England; and

Whereas, Mr. Simpson and details of his artwork have been featured in many national magazines and in several books; and

Whereas, the City of Wilson is developing the Vollis Simpson Whirligig Park to display a large collection of these whirligigs in historic downtown, which will be a one-of-a-kind destination for visitors; Now, therefore,
The General Assembly of North Carolina enacts:

SECTION 1. Chapter 145 of the General Statutes is amended by adding the following new sections to read:

"§ 145-41. State fossil.

The fossilized teeth of the megalodon shark is adopted as the official fossil of the State of North Carolina.

"§ 145-42. State frog.

The pine barrens tree frog (*Hyla andersonii*) is adopted as the official frog of the State of North Carolina.

"§ 145-43. State salamander.

The marbled salamander (*Ambystoma opacum*) is adopted as the official salamander of the State of North Carolina.

"§ 145-44. State marsupial.

The Virginia opossum (*Didelphis virginiana*) is adopted as the official marsupial of the State of North Carolina.

"§ 145-45. State folk art.

The whirligigs created by Vollis Simpson are adopted as the official folk art of the State of North Carolina."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H

2

HOUSE BILL 830
Committee Substitute Favorable 5/1/13

Short Title: Adopt State Symbols.

(Public)

Sponsors:

Referred to:

April 11, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO ADOPT AN OFFICIAL STATE FOSSIL, FROG, SALAMANDER,
3 MARSUPIAL, FOLK ART, AND ART MEDIUM.

4 Whereas, some of North Carolina's official State symbols have been suggested by
5 the State's school children after they have had history, science, social studies, or geography
6 lessons related to North Carolina; and

7 Whereas, this year some of the suggestions range from the adoption of an official
8 fossil to an official frog; and

9 Whereas, the State of North Carolina has a number of unique official symbols but
10 does not have an official fossil, frog, salamander, marsupial, folk art, or art medium; and

11 Whereas, the megalodon shark is an extinct shark species that lived over 1.5 million
12 years ago; and

13 Whereas, the megalodon shark may have reached over 40 feet in length and
14 weighed up to 100 tons; and

15 Whereas, the megalodon shark had serrated, heart-shaped teeth that may have
16 grown to over seven inches in length; and

17 Whereas, fossilized teeth of the megalodon shark have been found in North Carolina
18 and throughout the world; and

19 Whereas, North Carolina and the Southeast region of the United States lead the
20 world in amphibian diversity; and

21 Whereas, the pine barrens tree frog can be found in the Sandhills and Coastal Plain
22 regions of North Carolina; and

23 Whereas, the pine barrens tree frog has been considered one of the most striking and
24 beautiful frogs in the Southeast region of the United States; and

25 Whereas, the pine barrens tree frog by name reflects one of North Carolina's
26 signature trees and ecosystems that have been a vital part of the State's economic, cultural, and
27 natural history since colonial times; and

28 Whereas, North Carolina also leads the nation and world in salamander diversity,
29 most notably in our Appalachian Mountains; and

30 Whereas, the marbled salamander is found throughout the State and is unique in that
31 it is a charismatic, striking, chunky-bodied, fossorial amphibian, of which no two are exactly
32 alike in color pattern; and

33 Whereas, according to the North Carolina Wildlife Commission's 2005 North Carolina
34 Wildlife Action Plan, the pine barrens tree frog and the marbled salamander have been
35 identified as priority species for population monitoring and conservation in North Carolina; and



Whereas, the Virginia opossum is native to North Carolina and is the only marsupial found in North America; the female carries its underdeveloped young in a pouch until they are capable of living independently, similar to a kangaroo; and

Whereas, the Virginia opossum is one of the oldest and most primitive species of mammal found in North America; and

Whereas, the Virginia opossum is about the size of a large house cat with a triangular head; a long pointed nose; dark eyes; a long, scaly, prehensile tail; and short, black, leathery ears; and

Whereas, the Virginia opossum is nocturnal and lives in a wide variety of habitats, including deciduous forests, open woods, and farmland but prefers wet areas such as marshes, swamps, and streams; and

Whereas, at age 65, Vollis Simpson, a self-taught folk artist, began making giant windmills known as "whirligigs" at his home in Wilson, North Carolina; and

Whereas, Mr. Simpson's whirligigs have been exhibited at the North Carolina Museum of Art in Raleigh, the High Museum of Art in Atlanta, Georgia, and the Visionary Art Museum in Baltimore, Maryland, and at other locations, including New York, California, Canada, and England; and

Whereas, Mr. Simpson and details of his artwork have been featured in many national magazines and in several books; and

Whereas, the City of Wilson is developing the Vollis Simpson Whirligig Park to display a large collection of these whirligigs in historic downtown, which will be a one-of-a-kind destination for visitors; and

Whereas, North Carolina's clay-rich soil has contributed to the State's pottery heritage; and

Whereas, the use of clay has grown from the State's early Native Americans making mostly utilitarian wares and European settlers continuing the traditions of their ancestors to today's potters designing pottery with utilitarian and aesthetic elements; and

Whereas, the pottery tradition continues to thrive in North Carolina, especially in the Seagrove area, which includes parts of Chatham, Lee, Moore, Montgomery, and Randolph Counties; and

Whereas, clay continues to be an important art medium contributing to the State's cultural, social, and economic prosperity; Now, therefore,
The General Assembly of North Carolina enacts:

SECTION 1. Chapter 145 of the General Statutes is amended by adding the following new sections to read:

"§ 145-41. State fossil.

The fossilized teeth of the megalodon shark is adopted as the official fossil of the State of North Carolina.

"§ 145-42. State frog.

The pine barrens tree frog (*Hyla andersonii*) is adopted as the official frog of the State of North Carolina.

"§ 145-43. State salamander.

The marbled salamander (*Ambystoma opacum*) is adopted as the official salamander of the State of North Carolina.

"§ 145-44. State marsupial.

The Virginia opossum (*Didelphis virginiana*) is adopted as the official marsupial of the State of North Carolina.

"§ 145-45. State folk art.

The whirligigs created by Vollis Simpson are adopted as the official folk art of the State of North Carolina.

"§ 145-46. State art medium.

Clay is adopted as the official art medium of the State of North Carolina."

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



HOUSE BILL 830: Adopt State Symbols

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Reps. Avila, S. Martin, McElraft, West
Analysis of: Second Edition

Date: June 18, 2013
Prepared by: Theresa Matula
Committee Staff

SUMMARY: *House Bill 830 designates the official State fossil, frog, salamander, marsupial, folk art, and art medium.*

CURRENT LAW: Currently, North Carolina does not have an official state fossil, frog, salamander, marsupial, folk art, or art medium.

BILL ANALYSIS: House Bill 830 would make the following official State designations:

- State fossil: the fossilized teeth of the megalodon shark
- State frog: the pine barrens tree frog (*Hyla andersonii*)
- State salamander: the marbled salamander (*Ambystoma opacum*)
- State marsupial: the Virginia opossum (*Didelphis virginiana*)
- State folk art: the whirligigs created by Vollis Simpson
- State art medium: clay

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

BACKGROUND: The following are the current official State designations:

G.S. 145-1. State flower.	G.S. 145-21. State Aviation Hall of Fame and Museum & State Museum of Aviation.
G.S. 145-2. State bird.	G.S. 145-22. State carnivorous plant
G.S. 145-3. State tree.	G.S. 145-23. State birthplace of traditional pottery
G.S. 145-4. State shell.	G.S. 145-24. Official State dances
G.S. 145-5. State mammal.	G.S. 145-25. State Christmas tree
G.S. 145-6. State saltwater fish.	G.S. 145-26. State freshwater trout
G.S. 145-7. State insect.	G.S. 145-27. State Collard Festival
G.S. 145-8. State stone.	G.S. 145-28. State food festival
G.S. 145-9. State reptile.	G.S. 145-29. State community theater
G.S. 145-10. State rock.	G.S. 145-30. State potato festival
G.S. 145-10.1. State beverage.	G.S. 145-31. State horse
G.S. 145-11. State historical boat.	G.S. 145-32. Honor and Remember Flag
G.S. 145-12. State language.	G.S. 145-33. State shad festival
G.S. 145-13. The State dog.	G.S. 145-34. State herring festival
G.S. 145-14. The State Military Academy.	G.S. 145-35. State mineral
G.S. 145-15. State tartan.	G.S. 145-36. State sport
G.S. 145-16. State Watermelon Festivals.	G.S. 145-37. State Shrimp Festival
G.S. 145-17. State vegetable.	G.S. 145-38. State butterfly
G.S. 145-18. State fruit and State berries.	G.S. 145-39. State spring and fall livermush festivals
G.S. 145-19. State International Festival	G.S. 145-40. State mullet festival
G.S. 145-20. State wildflower	

**Wendy Graf Ray and Bill Patterson, staff to the House Rules Committee, substantially contributed to this summary.*

O. Walker Reagan
Director



Research Division
(919) 733-2578

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Th Ue	ECU
Jon Carr	Jordan Price
Christine Cunn	WakeMed
Bruce Schmel	Reedley
Kay Emanuel	School of Government
Buck LATTIMORE	NC CHIROPRACTIC ASSOC.
VANCE KINLAW	NC BO. OF CHIROPRACTIC EXAM.
DYLAN WATTI	SMITH ANDERSON
Sachi Pathak	Shadowing Sen. Kinraird
Chris Sigman	Intern - Sen. Kinraird
George Reddin	Governor's Page
Jaeger Parsons	governors page
Barrett Adam	gov. page
Becky Bauerband	LA to Rep. Faircloth
Bill Rustin	ACP
Mike James	ACP
Richard O'Brien	PFFPNC

Hise-Pate

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 6-19 TIME: 11 AM

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

Page Name	Hometown	Sponsoring Senator
1. Emma Nance	Rutherfordton	Hise
2. Allyson Yelton	Rutherfordton	Hise
3. JC Barringer	~~ATLANTA~~ Cary	Allman
4. JAKE BAXTON	Stells	Brown
5. Gordon Ma	Cary	Stein
6. Ty Van de Zande	Raleigh	Blue
7. Parker Lee	Fuquay Varina	Sanderson
8. ^{Tarik} Tarik Zikry	Chapel Hill	Kinnaird
9.		
10.		

Do not add names below the grid.

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

SIGN-IN SHEET FOR SPEAKERS

(please print)

Bill 467

Name: Dr. Margaret Bertrand Organization: Radiologist- Greensboro

Name: Gina Waters Organization: Survivor

Name: Addy Jeffrey Organization: Survivor

Name: Bruc Schröder Organization: Radiologist - Greenville

Name: _____ Organization: _____

Name: _____ Organization: _____

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Andy Ellis	NCRN
William Parker	NC Association of Pharmacists
Quita Davis Gatten	NCAP / KROGER / NCRMA
Alex Miller	KL6
Colleen Kochanele	KL6
Mary Thompson	Weyerhaeuser
Peyton Strickland	VISITOR
Chari Feldman	Maxim Healthcare

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

June 19, 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Matt Viohl	Ch2 Consult
Andy Chase	KMA
David Holbaker	N.C. Board of Nursing
Jesse Guzman	DHHS / DHQR
TRACY COLVARD	ATHE
Dean Pluhett	PS
Julia Adams	The Arc NC/NCARF
AnnaLiese Dalph	DL
Jeff Johnson	UNC School of Pharmacy
Tarra Palnok	Walgreens
Russell PALK	MEDIMMUNE
North Carolina	Atty Gen
Heather Danner	MEMA
Jennifer Hawkins	ST Board Opticians
Sue M. Haggerty	NC State Board of Opticians
Eric Childs	Attorney
Julia J. Thomas	NCAAP; NCAAA

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Wendy Koz	Policy Group
Joel Maynard	GRM's Assoc
Daniel Kruatz	Dept. of Admin., Governor Page
Daniel Wynne	Governor Page
Elizabeth Tellefsen	Governor Page
Zach Blinson	Governor's Page
Alex Boger	CSS
Sarah Wolfe	MNC LLC

**Senate Committee on Health Care
Wednesday, June 26, 2013
544 Legislative Office Building
Senator Ralph Hise, Presiding**

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills:

BILL NO.	SHORT TITLE	SPONSOR
HB 392	Warrant Status/Drug Screen Public Assist.	Representative Arp Representative Horn Representative Starnes Representative Burr

Adjournment

**Senate Committee on Health Care
Wednesday, June 26, 2013 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on June 26, 2013, in Room 544 of the Legislative Office Building. Nineteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing the pages—Evan Harakas, Cammie Holland, Reaves Houston, Mackenzie Lander, Mark Macon II, Anna Marrujo, and Tharon Suggs; and the Sergeants-at-Arms—Donna Blake, Charles Harper, Steve McKaig, Anderson Meadows, and Charles Harper.

Senator Hise introduced a PCS for House Bill 392—Warrant Status/Drug Screen Public Assist. for consideration and Senator Allran moved for adoption of the PCS. The motion passed.

Representatives Dean Arp and Sarah Stevens presented the PCS and explained its purpose. They and staff answered questions from the committee about the PCS.

Senator Bingham moved for a favorable report to the PCS, unfavorable as to the original bill. The motion passed.

The meeting adjourned at 11:40 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Tuesday, June 25, 2013 03:16 PM
To: 'Rep. Edgar Starnes'; 'Rep. Justin Burr'; 'Rep. Craig Horn'; 'Rep. Dean Arp'
Cc: Pattie Fleming (Rep. Edgar Starnes); Dina Long (Rep. Justin Burr); Steven Franklin (Rep. Craig Horn); Wendy Miller (Rep. Dean Arp)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Wednesday, June 26, 2013 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	June 26, 2013	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	
HB 392	Share Arrest Warrant Status/Pub. Assistance.	Representative Arp Representative Horn Representative Starnes Representative Burr

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, June 26, 2013

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

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

HB 392 (CS#1)

Share Arrest Warrant Status/Pub. Assistance.

Draft Number: H392-PCS80405-TK-48

Sequential Referral: None

Recommended Referral: None

Long Title Amended: Yes

TOTAL REPORTED: 1

Senator James Davis will handle HB 392



* C M R 8 1 6 - V - 1 *

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

H

1

HOUSE BILL 392

Short Title: Share Arrest Warrant Status/Pub. Assistance. (Public)

Sponsors: Representatives Arp, Horn, Starnes, and Burr (Primary Sponsors).

For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.

Referred to: Health and Human Services.

March 21, 2013

A BILL TO BE ENTITLED

AN ACT REQUIRING A COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS) TO CONDUCT A CRIMINAL CHECK ON APPLICANTS FOR OR RECIPIENTS OF TEMPORARY ASSISTANCE TO NEEDY FAMILY (TANF) BENEFITS OR FOOD AND NUTRITION SERVICES (FNS) BENEFITS, TO REQUIRE DSS TO SHARE INFORMATION WITH A LOCAL LAW ENFORCEMENT AGENCY REGARDING AN APPLICANT FOR OR RECIPIENT OF TANF OR FNS BENEFITS WHO HAS AN OUTSTANDING ARREST WARRANT, AND TO DENY TANF OR FNS BENEFITS TO AN APPLICANT OR RECIPIENT SUBJECT TO AN OUTSTANDING WARRANT FOR A FELONY OR FOR A PROBATION OR PAROLE VIOLATION.

Whereas, federal law, specifically, 42 U.S.C. § 601, et seq., requires that states receiving funds under certain federal grant programs shall not use any part of the grant to provide assistance to any individual who is (i) fleeing to avoid prosecution, custody, or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or (ii) violating a condition of probation or parole imposed under federal or State law; and

Whereas, states receiving these federal grant funds are authorized under federal law to establish safeguards against the use or disclosure of information about applicants or recipients for assistance under the state program funded under federal law; and

Whereas, federal law expressly authorizes the State agency administering the program to furnish a federal, State, or local law enforcement officer, upon the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the applicant or recipient under specified circumstances; and

Whereas, conducting a criminal background check on applicants for or recipients of public assistance benefits is necessary in order to ensure compliance with federal laws prohibiting a fleeing felon or probation or parole violator from receiving public assistance benefits; and

Whereas, the apprehension of individuals by law enforcement may be necessary to protect and safeguard the public; and

Whereas, State agencies administering the program may have or receive information that is necessary for a law enforcement agency to conduct the official duties of the agency, and the location or apprehension of the applicant or recipient is within a law enforcement agency's official duties; Now, therefore,

The General Assembly of North Carolina enacts:



* H 3 9 2 - V - 1 *

SECTION 1. Part 1 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"§ 108A-26.1. Information sharing of outstanding arrest warrant of applicant for or recipient of program assistance.

(a) A county department of social services shall notify an applicant for program assistance under Part 2 or Part 5 of this Article that release of confidential information from the applicant's records may not be protected if a felony or misdemeanor arrest warrant is issued against the applicant. A county department of social services shall notify all recipients under a program of public assistance under Part 2 or Part 5 of this Article at the time of renewal of the recipient's application for such program assistance that release of confidential information from the recipient's records may not be protected if a felony or misdemeanor arrest warrant is issued against the recipient.

(b) Notwithstanding G.S. 108A-80 and to the extent otherwise allowed by federal and State law, a county department of social services shall conduct a criminal history record check of an applicant for or recipient of program assistance under Part 2 or Part 5 of this Article. The county department of social services shall ensure that the State and national criminal history of an applicant, or of a recipient at the time of benefits renewal, is checked. If an applicant or recipient's criminal history record check reveals that a warrant has been issued for the arrest of the applicant or recipient for the commission of a felony or a misdemeanor, the county department of social services shall, within 24 hours or by the end of the next business day after receiving information of the existence of the warrant for arrest, notify a local law enforcement agency in the county where the applicant or recipient is seeking benefits of the existence of the warrant for arrest. Information that may be released pursuant to this section shall be limited to the name, address, telephone number, Social Security number, birth date, and physical description of the applicant for or recipient of program assistance. Except as otherwise provided by this section, the county department of social services shall keep all information obtained pursuant to this section confidential.

(c) Nothing in this section shall be construed to authorize the disclosure of any information otherwise protected by State or federal law or regulation.

(d) This section applies to applicants for or recipients of program assistance under Part 2 or Part 5 of this Article only.

(e) The Social Services Commission shall adopt rules regarding (i) the sharing of information between county departments of social services and local law enforcement agencies; (ii) the accuracy of information shared pursuant to this section; and (iii) any other rules the Commission deems necessary to implement this section. The Secretary of the Department of Health and Human Services shall oversee implementation of these rules.

(f) Each county department of social services is authorized to enter into a Memorandum of Agreement or Memorandum of Understanding with the head of any law enforcement agency as defined in G.S. 90-95.2 in order to perform the functions described in this section."

SECTION 2. Part 1 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"§ 108A-26.2. Individual subject to felony charge; eligibility for program assistance; federal approval; review by department.

(a) Subject to subsection (b), a department of social services shall not grant public assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the General Statutes if the department receives information described in G.S. 108A-26.1 that the applicant for or recipient of program assistance is subject to arrest under an outstanding warrant arising from a charge of violating conditions of parole or probation or from a felony charge against that applicant or recipient in any jurisdiction. This section does not affect the eligibility for assistance of other members of the applicant or recipient's household. An applicant or recipient described in this

1 section is eligible for program assistance, if all other eligibility criteria of the law are met, when
2 the applicant or recipient is no longer subject to arrest under an outstanding warrant as
3 described in this section.

4 (b) If federal approval is required in order to prevent the loss of federal reimbursement
5 as a result of the application of this section to an applicant for or recipient of program
6 assistance, the department of social services shall promptly take any action necessary to obtain
7 federal approval."

8 **SECTION 3.** Part 2 of Article 4 of Chapter 114 of the General Statutes is amended
9 by adding the following new section to read:

10 **"§ 114-19.33. Criminal record checks of applicants for or recipients of program**
11 **assistance.**

12 The Department of Justice may provide to a county department of social services from the
13 State and National Repositories of Criminal Histories the criminal history of any person who
14 applies for program assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the
15 General Statutes. The county department of social services shall provide to the Department of
16 Justice, along with the request, a form signed by the applicant or recipient acknowledging
17 receipt of the notification required by G.S. 108A-26.1(a), and any identifying information
18 required by the State and National Repositories, and any additional information required by the
19 Department of Justice. Except as provided under G.S. 108A-26.1, the county department of
20 social services shall keep all information obtained pursuant to this section confidential."

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

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

H

D

**HOUSE BILL 392
Committee Substitute Favorable 4/3/13
Third Edition Engrossed 4/9/13
PROPOSED SENATE COMMITTEE SUBSTITUTE H392-CSTK-48 [v.8]
6/25/2013 4:04:37 PM**

Short Title: Warrant Status/Drug Screen Public Assist.

(Public)

Sponsors:

Referred to:

March 21, 2013

A BILL TO BE ENTITLED

AN ACT REQUIRING A COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS) TO VERIFY WHETHER AN APPLICANT FOR OR RECIPIENT OF TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BENEFITS OR FOOD AND NUTRITION SERVICES (FNS) BENEFITS IS A FLEEING FELON OR A PROBATION OR PAROLE VIOLATOR, TO DIRECT INTERAGENCY COOPERATION AND INFORMATION SHARING IN ORDER TO VERIFY THE ELIGIBILITY STATUS OF AN APPLICANT OR RECIPIENT, TO DENY TANF OR FNS BENEFITS TO AN APPLICANT OR RECIPIENT WHO IS A FLEEING FELON OR A PROBATION OR PAROLE VIOLATOR, AND TO REQUIRE DRUG SCREENING AND TESTING FOR CERTAIN APPLICANTS AND RECIPIENTS OF WORK FIRST PROGRAM ASSISTANCE.

Whereas, federal law, specifically, 42 U.S.C. § 601, et seq., requires that states receiving funds under certain federal grant programs shall not use any part of the grant to provide assistance to any individual who is (i) fleeing to avoid prosecution, custody, or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees or (ii) violating a condition of probation or parole imposed under federal or State law; and

Whereas, states receiving these federal grant funds are authorized under federal law to establish safeguards against the use or disclosure of information about applicants or recipients for assistance under the state program funded under federal law; and

Whereas, federal law expressly authorizes the State agency administering the program to furnish a federal, State, or local law enforcement officer, upon the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the applicant or recipient under specified circumstances; and

Whereas, conducting a criminal background check on applicants for or recipients of public assistance benefits is necessary in order to ensure compliance with federal laws prohibiting a fleeing felon or probation or parole violator from receiving public assistance benefits; and

Whereas, the apprehension of individuals by law enforcement may be necessary to protect and safeguard the public; and

Whereas, State agencies administering the program may have or receive information that is necessary for a law enforcement agency to conduct the official duties of the agency, and



* H 3 9 2 - C S T K - 4 8 - V - 8 *

the location or apprehension of the applicant or recipient is within a law enforcement agency's official duties; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. SHARE ARREST WARRANT STATUS OF APPLICANTS FOR PUBLIC ASSISTANCE

SECTION 1. Part 1 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"§ 108A-26.1. Information sharing of outstanding arrest warrant of applicant for or recipient of program assistance.

(a) A county department of social services shall notify an applicant for program assistance under Part 2 or Part 5 of this Article that release of confidential information from the applicant's records may not be protected if a warrant for arrest is issued against the applicant. A county department of social services shall notify all recipients under a program of public assistance under Part 2 or Part 5 of this Article at the time of renewal of the recipient's application for such program assistance that release of confidential information from the recipient's records may not be protected if a felony or misdemeanor arrest warrant is issued against the recipient.

(b) Notwithstanding G.S. 108A-80, and to the extent otherwise allowed by federal and State law, a county department of social services shall verify whether an applicant for or recipient of program assistance under Part 2 or Part 5 of this Article is (i) fleeing to avoid prosecution, custody, or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees or (ii) violating a condition of probation or parole imposed under federal or State law, by ensuring that the criminal history of an applicant, or of a recipient at the time of benefits renewal, is checked. A county department of social services shall conduct the criminal history check necessary to verify whether an applicant is a fleeing felon or a probation or parole violator utilizing all currently accessible databases to the extent permitted by allocated county and state resources. Counties are not required to allocate funds for this program but are authorized to do so on a voluntary basis.

(c) Nothing in this section shall be construed to authorize the disclosure of any information otherwise protected by State or federal law or regulation.

(d) This section applies to applicants for or recipients of program assistance under Part 2 or Part 5 of this Article only.

(e) The Social Services Commission shall adopt rules regarding (i) the sharing of information between county departments of social services and local law enforcement agencies, (ii) the accuracy of information shared pursuant to this section, and (iii) any other rules the Commission deems necessary to implement this section. The Secretary of the Department of Health and Human Services shall oversee implementation of these rules.

(f) The Secretary of the Department of Health and Human Services shall promote cooperation among State and local agencies to perform the functions described in this section. The Department of Health and Human Services shall cooperate and collaborate with the Office of the State Controller, the Administrative Office of the Courts, and the Department of Public Safety to develop protocols to implement this section.

(g) Annually, on April 1, each county department of social services shall report to the Department of Health and Human Services on the number of individuals who are denied benefits under this section during the preceding calendar year.

(h) Annually, on May 1, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services of the General Assembly on the number of individuals who are denied assistance under this section. The report shall include a breakdown by county."

1 **SECTION 2.** Part 1 of Article 2 of Chapter 108A of the General Statutes is
2 amended by adding the following new section to read:

3 **"§ 108A-26.2. Fleeing felon, or parole or probation violator; eligibility for program**
4 **assistance; federal approval; review by department.**

5 (a) Subject to subsection (b) of this section, a department of social services shall not
6 grant public assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the General
7 Statutes if the department receives information described in G.S. 108A-26.1 that the applicant
8 for or recipient of program assistance is subject to arrest under an outstanding warrant arising
9 from a charge of violating conditions of parole or probation or from a felony charge against that
10 applicant or recipient in any jurisdiction. This section does not affect the eligibility for
11 assistance of other members of the applicant's or recipient's household. An applicant or
12 recipient described in this section is eligible for program assistance, if all other eligibility
13 criteria of the law are met, when the applicant or recipient is no longer subject to arrest under
14 an outstanding warrant as described in this section.

15 (b) If federal approval is required in order to prevent the loss of federal reimbursement
16 as a result of the application of this section to an applicant for or recipient of program
17 assistance, the Department of Health and Human Services shall promptly take any action
18 necessary to obtain federal approval."

19 **SECTION 3.** Part 2 of Article 4 of Chapter 114 of the General Statutes is amended
20 by adding the following new section to read:

21 **"§ 114-19.33. Criminal record checks of applicants for or recipients of program**
22 **assistance.**

23 The Department of Justice may provide to a county department of social services from the
24 State and National Repositories of Criminal Histories the criminal history of any person who
25 applies for program assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the
26 General Statutes. The county department of social services shall provide to the Department of
27 Justice, along with the request, a form signed by the applicant or recipient acknowledging
28 receipt of the notification required by G.S. 108A-26.1(a) and any identifying information
29 required by the State and National Repositories and any additional information required by the
30 Department of Justice. Except as provided under G.S. 108A-26.1, the county department of
31 social services shall keep all information obtained pursuant to this section confidential."

32
33 **PART II. DRUG SCREENING AND TESTING FOR WORK FIRST PROGRAM**
34 **ASSISTANCE.**

35 **SECTION 4.** G.S. 108A-29.1 reads as rewritten:

36 **"§ 108A-29.1. Substance abuse treatment required; drug-D~~rug~~ screening and testing for**
37 **Work First Program applicants and recipients.**

38 (a) ~~Each applicant or current recipient of Work First Program benefits, determined by a~~
39 ~~Qualified Professional in Substance Abuse (QPSA) or by a physician certified by the American~~
40 ~~Society of Addiction Medicine (ASAM) to be addicted to alcohol or drugs and to be in need of~~
41 ~~professional substance abuse treatment services shall be required, as part of the person's MRA~~
42 ~~and as a condition to receiving Work First Program benefits, to participate satisfactorily in an~~
43 ~~individualized plan of treatment in an appropriate treatment program. As a mandatory program~~
44 ~~component of participation in an addiction treatment program, each applicant or current~~
45 ~~recipient shall be required to submit to an approved, reliable, and professionally administered~~
46 ~~regimen of testing for presence of alcohol or drugs, without advance notice, during and after~~
47 ~~participation, in accordance with the addiction treatment program's individualized plan of~~
48 ~~treatment, follow up, and continuing care services for the applicant or current recipient. The~~
49 ~~Department shall require a drug test to screen each applicant for or recipient of Work First~~
50 ~~Program assistance whom the Department reasonably suspects is engaged in the illegal use of~~
51 ~~controlled substances. The cost of the drug testing is the responsibility of the individual tested.~~

The Department shall provide notice of drug testing to each applicant or recipient. The notice shall advise the applicant or recipient that drug screening, and testing if there is reasonable suspicion that an individual is engaged in the illegal use of controlled substances, will be conducted as a condition of receiving Work First Program assistance, and that the results of the drug tests will remain confidential and will not be released to law enforcement. The applicant or recipient shall be advised that the required drug screening and testing may be avoided if the applicant or recipient does not apply for Work First Program assistance. Dependent children under the age of 18 are exempt from the requirements of this section. The Department shall require the following:

- (1) That for two-parent households, both parents comply with the requirements of this section.
- (2) That any teen parent who is emancipated pursuant to Article 35 of Chapter 7B of the General Statutes comply with the requirements of this section.
- (3) That each applicant or recipient be advised before drug testing that he or she may inform the agent administering the test of any prescription or over-the-counter medication he or she is taking.
- (4) That each applicant or recipient being tested sign a written acknowledgement that he or she has received and understood the notice and advice provided under this subsection.
- (5) That each applicant or recipient who fails a drug test understands that he or she has the right to take one or more additional tests.

(b) ~~An applicant or current recipient who fails to comply with any requirement imposed pursuant to this section shall not be eligible for benefits or shall be subject to the termination of benefits, but shall be considered to be receiving benefits for purposes of determining eligibility for medical assistance.~~ For an applicant or current recipient who is required to undergo a drug test and who tests negative for controlled substances, the Department shall increase the amount of the initial Work First Program assistance by the amount paid by the applicant or recipient for the drug testing. An applicant or recipient who tests positive for controlled substances as a result of a drug test required under this section is ineligible to receive Work First Program assistance for one year from the date of the positive drug test except as provided in subsection (b1) of this section. The individual may reapply after one year. However, if the individual has any subsequent positive drug tests, the individual shall be ineligible for benefits for three years from the date of the subsequent positive drug test unless the individual reapplies pursuant to subsection (b1) of this section.

(b1) An applicant or recipient deemed ineligible under subsection (b) of this section may reapply for Work First Program assistance if the individual can document the successful completion of a substance abuse treatment program offered by a provider under subsection (e) of this section and licensed by the Department. The applicant or recipient who reapplies for Work First Program assistance after completion of a substance abuse program shall pass a drug test. The cost of any drug testing and substance abuse program provided under this subsection shall be the responsibility of the applicant or recipient being tested and receiving treatment. An applicant or recipient who reapplies for Work First Program assistance pursuant to this subsection may reapply one time only.

(c) The children of any applicant or current recipient shall remain eligible for benefits, and these benefits shall be paid to a protective payee pursuant to G.S. 108A-38.

(d) ~~An applicant or current recipient shall not be regarded as failing to comply with the requirements of this section if an appropriate drug or alcohol treatment program is unavailable.~~ The Social Services Commission shall adopt rules pertaining to the testing of applicants and recipients under this section.

(e) Area mental health authorities organized pursuant to Article 4 of Chapter 122C of the General Statutes shall be responsible for administering the provisions of this section.

1 (f) ~~The requirements of this section may be waived or modified as necessary in the case~~
2 ~~of individual applicants or recipients to the degree necessary to comply with Medicaid~~
3 ~~eligibility provisions.~~

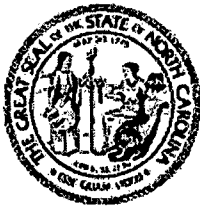
4 (g) For the purposes of this section, a criminal record check of an applicant for or
5 recipient of Work First Program assistance conducted under G.S. 114-19.33 that discloses a
6 conviction, arrest, or outstanding warrant, within the three years prior to the date the criminal
7 record check is conducted, relating to illegal controlled substances shall constitute reasonable
8 suspicion under this section and that applicant or recipient shall be required to undergo drug
9 testing as a condition of receipt of Work First Program assistance benefits."

10 **SECTION 5.** The Department of Health and Human Services shall report to the
11 General Assembly no later than July 1, 2014, on the implementation of Section 4 of this act.
12

13 **PART III. EFFECTIVE DATE AND SEVERABILITY**

14
15 **SECTION 6.** If any provision of this act or its application is held invalid, the
16 invalidity does not affect other provisions or applications of this act that can be given effect
17 without the invalid provisions or application, and to this end the provisions of this act are
18 severable.

19 **SECTION 7.** This act becomes effective October 1, 2013.
20



This Bill Analysis
reflects the contents
of the bill as it was
presented in
committee.

HOUSE BILL 392: Warrant Status/Drug Screen Public Assist.

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Reps. Arp, Horn, Starnes, Burr
Analysis of: PCS to Third Edition
H392-CSTK-48

Date: June 24, 2013
Prepared by: Amy Jo Johnson*
Committee Counsel

SUMMARY: *House Bill 392 would require a county department of social services (DSS) to verify whether an applicant for, or recipient of, Temporary Assistance to Needy Family (TANF) or Food and Nutrition Services (FNS) benefits is a fleeing felon or a probation or parole violator. The act would further deny TANF or FNS benefits to an applicant or recipient subject to an outstanding arrest warrant for a felony or for a probation or parole violation, but would not affect the eligibility of a member of the individual's household for those benefits. The PCS also requires drug screening and testing for applicants for or recipients of Work First Program assistance for whom there is reasonable suspicion to believe the individual is engaged in the illegal use of controlled substances.*

The PCS adds Section 4 and 5 of the bill involving drug screening of Work First Program assistance applicants or recipients. The PCS also changes the effective date of the bill.

BILL ANALYSIS: Section 1 of the bill would do the following:

- Create a new G.S. 108A-26.1, requiring a county DSS to notify an applicant for, or recipient of, TANF or FNS benefits that confidential information from the individual's record may be released if a felony, misdemeanor, or felony probation or parole violation arrest warrant is issued against the individual. The notification must be given at the time the application is made or, for current public assistance recipients, at the time of application renewal.
- Require DSS to verify whether an applicant is fleeing to avoid prosecution, custody, or confinement after conviction for a felony or violating a condition of probation or parole, by ensuring that the criminal history of an applicant, or of a recipient at the time of benefits renewal, is checked.
- Direct the Social Services Commission to adopt rules relating to the sharing of information between county departments of social services and local law enforcement agencies, the accuracy of shared information, and any other rules the Commission deems necessary.
- Direct the DHHS to promote cooperation among State and local agencies to perform these functions and collaborate with the Office of the State Controller, the Administrative Office of the Courts, and the Department of Public Safety to develop protocols to implement this statute.
- Require that, annually, each county DSS report to DHHS, and that DHHS in turn report to the General Assembly, on the number of individuals denied services under these provisions.

Section 2 of the bill would create in the chapter on social services a new section, G.S. 108A-26.2, to provide that:

- County departments of social services will not grant public assistance under Parts 2 or 5 of Article 2 of G.S. 108A (TANF and FNS benefits) if they receive information that the

O. Walker Reagan
Director



* H 3 9 2 - S M T K - 1 0 0 C S T K - 4 8 - V 5 *

Research Division
(919) 733-2578

House PCS 392

Page 2

applicant/recipient is subject to arrest on an outstanding warrant for a parole or probation violation or for a felony charge.

- The benefits eligibility of members of the individual's household will not be affected.
- If all other eligibility criteria are met, an applicant/recipient would become eligible for program assistance when the individual is no longer subject to arrest under the outstanding warrant.

Section 3 would create a new G.S. 114-19.33, "Criminal record checks of applicants for or recipients of program assistance," authorizing the Department of Justice (DOJ) to provide to a county DSS, from the State and National Repositories of Criminal Histories, the criminal history of anyone applying for TANF or FNS assistance. In addition to a request for information, the county DSS must provide to the DOJ a form signed by the applicant/recipient acknowledging receipt of notification required by new G.S. 108A-26.1(a), any identifying information required by the State and National Repositories, and any other information required by the DOJ. Except as provided by G.S. 108A-26.1, DSS must keep all information obtained under this section confidential.

Section 4 of the PCS requires the following of DHHS:

- To administer a drug test to screen each applicant for or recipient of Work First benefits whom DHHS reasonable suspects is engaged in the illegal use of controlled substances.
 - Dependent children under age 18 are exempt.
 - Both parents of a two-parent household and lawfully emancipated teen parents must be comply.
- To provide notice of drug testing to each applicant or recipient. This notice shall:
 - Inform the applicant/recipient that drug screening/testing is required as a condition of receiving Work First assistance, and that the test may be avoided if the person does not apply.
 - Advise the individual that test results are confidential and will not be released to law enforcement.
- To advise individuals that they may tell the test administrator about any medications the individual is taking.
- To determine ineligible an individual who tests positive for controlled substances as provided under G.S. 108A-29.1.

The cost of the drug testing would be the responsibility of the individual tested. If the person tests negative, the initial payment of benefits would include reimbursement of the cost of the drug testing.

A person who tests positive would be ineligible to receive Work First Program assistance for a period of one year from the date of the positive drug test, and may reapply after one year; a person who has a subsequent positive drug test would be ineligible for a period of three years from the date of the subsequent drug test. However, a person would be eligible to reapply with documentation of successful completion of a substance abuse treatment program offered by an area mental health authority and licensed by DHHS. The applicant who reapplies after completion of a treatment program would be required to pass a drug test, and would be responsible for the cost of the test. A person may only reapply one time based on completion of a substance abuse treatment program. The Social Services Commission would be required to adopt rules pertaining to the testing of applicants and recipients.

Criminal record checks conducted pursuant to **Section 3** of the PCs that disclose a conviction, arrest, or outstanding warrant within three years prior to the date the record check is conducted, relating to illegal controlled substances constitutes reasonable suspicion and the applicant or recipient will be required to undergo drug testing.

House PCS 392

Page 3

Section 5 of the PCS requires DHHS report to the General Assembly no later than July 1, 2014, on the implementation **Section 4** of this act.

EFFECTIVE DATE: This act becomes effective October 1, 2013.

BACKGROUND: As stated in the prefatory section (the "whereas" clauses), in order to receive federal funds for certain public assistance benefits, the federal government, under 42 U.S. Code 608 et seq., specifies certain conditions under which a state must exchange information with law enforcement agencies. Federal law gives states some further discretion to determine eligibility for TANF and FNS benefits, and therefore a state may develop additional requirements if it establishes safeguards against the use or disclosure of information about applicants for or recipients of TANF or FNS assistance.

Through Work First, North Carolina's Temporary Assistance for Needy Families (TANF) program, parents can get short-term training and other services to help them become employed and self-sufficient. The Work First Program is governed by Part 2 of Article 2 of Chapter 108A of the General Statutes (G.S. 108A-27 through 108A-39). G.S. 108A-29.1 requires that each applicant or recipient of Work First Program benefits who is determined by a substance abuse professional or physician to be addicted to alcohol or drugs and to be in need of professional substance abuse treatment services must participate satisfactorily in an individualized plan of treatment. As a mandatory component of participation in an addiction treatment program, an applicant or recipient is required to submit to testing for the presence of alcohol or drugs.

**Janice Paul, Brenda Carter and Susan Sitze, Research Division, contributed substantially to this summary.*

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

H

3

**HOUSE BILL 392
Committee Substitute Favorable 4/3/13
Third Edition Engrossed 4/11/13**

Short Title: Share Arrest Warrant Status/Pub. Assistance.

(Public)

Sponsors:

Referred to:

March 21, 2013

A BILL TO BE ENTITLED

AN ACT REQUIRING A COUNTY DEPARTMENT OF SOCIAL SERVICES (DSS) TO VERIFY WHETHER AN APPLICANT FOR OR RECIPIENT OF TEMPORARY ASSISTANCE TO NEEDY FAMILY (TANF) BENEFITS OR FOOD AND NUTRITION SERVICES (FNS) BENEFITS IS A FLEEING FELON OR A PROBATION OR PAROLE VIOLATOR, TO DIRECT INTERAGENCY COOPERATION AND INFORMATION SHARING IN ORDER TO VERIFY THE ELIGIBILITY STATUS OF AN APPLICANT OR RECIPIENT, AND TO DENY TANF OR FNS BENEFITS TO AN APPLICANT OR RECIPIENT WHO IS A FLEEING FELON OR A PROBATION OR PAROLE VIOLATOR.

Whereas, federal law, specifically, 42 U.S.C. § 601, et seq., requires that states receiving funds under certain federal grant programs shall not use any part of the grant to provide assistance to any individual who is (i) fleeing to avoid prosecution, custody, or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees or (ii) violating a condition of probation or parole imposed under federal or State law; and

Whereas, states receiving these federal grant funds are authorized under federal law to establish safeguards against the use or disclosure of information about applicants or recipients for assistance under the state program funded under federal law; and

Whereas, federal law expressly authorizes the State agency administering the program to furnish a federal, State, or local law enforcement officer, upon the request of the officer, with the current address of any recipient if the officer furnishes the agency with the name of the applicant or recipient under specified circumstances; and

Whereas, conducting a criminal background check on applicants for or recipients of public assistance benefits is necessary in order to ensure compliance with federal laws prohibiting a fleeing felon or probation or parole violator from receiving public assistance benefits; and

Whereas, the apprehension of individuals by law enforcement may be necessary to protect and safeguard the public; and

Whereas, State agencies administering the program may have or receive information that is necessary for a law enforcement agency to conduct the official duties of the agency, and the location or apprehension of the applicant or recipient is within a law enforcement agency's official duties; Now, therefore,

The General Assembly of North Carolina enacts:



1 **SECTION 1.** Part 1 of Article 2 of Chapter 108A of the General Statutes is
2 amended by adding the following new section to read:

3 **"§ 108A-26.1. Information sharing of outstanding arrest warrant of applicant for or**
4 **recipient of program assistance.**

5 (a) A county department of social services shall notify an applicant for program
6 assistance under Part 2 or Part 5 of this Article that release of confidential information from the
7 applicant's records may not be protected if a warrant for arrest is issued against the applicant. A
8 county department of social services shall notify all recipients under a program of public
9 assistance under Part 2 or Part 5 of this Article at the time of renewal of the recipient's
10 application for such program assistance that release of confidential information from the
11 recipient's records may not be protected if a felony or misdemeanor arrest warrant is issued
12 against the recipient.

13 (b) Notwithstanding G.S. 108A-80, and to the extent otherwise allowed by federal and
14 State law, a county department of social services shall verify whether an applicant for or
15 recipient of program assistance under Part 2 or Part 5 of this Article is (i) fleeing to avoid
16 prosecution, custody, or confinement after conviction, under the laws of the place from which
17 the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the
18 laws of the place from which the individual flees or (ii) violating a condition of probation or
19 parole imposed under federal or State law, by ensuring that the criminal history of an applicant,
20 or of a recipient at the time of benefits renewal, is checked. A county department of social
21 services shall conduct the criminal history check necessary to verify whether an applicant is a
22 fleeing felon or a probation or parole violator utilizing all currently accessible databases to the
23 extent permitted by allocated county and state resources. Counties are not required to allocate
24 funds for this program but are authorized to do so on a voluntary basis.

25 (c) Nothing in this section shall be construed to authorize the disclosure of any
26 information otherwise protected by State or federal law or regulation.

27 (d) This section applies to applicants for or recipients of program assistance under Part
28 2 or Part 5 of this Article only.

29 (e) The Social Services Commission shall adopt rules regarding (i) the sharing of
30 information between county departments of social services and local law enforcement agencies,
31 (ii) the accuracy of information shared pursuant to this section, and (iii) any other rules the
32 Commission deems necessary to implement this section. The Secretary of the Department of
33 Health and Human Services shall oversee implementation of these rules.

34 (f) The Secretary of the Department of Health and Human Services shall promote
35 cooperation among State and local agencies to perform the functions described in this section.
36 The Department of Health and Human Services shall cooperate and collaborate with the Office
37 of the State Controller, the Administrative Office of the Courts, and the Department of Public
38 Safety to develop protocols to implement this section.

39 (g) Annually, on April 1, each county department of social services shall report to the
40 Department of Health and Human Services on the number of individuals who are denied
41 benefits under this section during the preceding calendar year.

42 (h) Annually, on May 1, the Department of Health and Human Services shall report to
43 the Joint Legislative Oversight Committee on Health and Human Services of the General
44 Assembly on the number of individuals who are denied assistance under this section. The
45 report shall include a breakdown by county."

46 **SECTION 2.** Part 1 of Article 2 of Chapter 108A of the General Statutes is
47 amended by adding the following new section to read:

48 **"§ 108A-26.2. Fleeing felon, or parole or probation violator; eligibility for program**
49 **assistance; federal approval; review by department.**

50 (a) Subject to subsection (b) of this section, a department of social services shall not
51 grant public assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the General

1 Statutes if the department receives information described in G.S. 108A-26.1 that the applicant
2 for or recipient of program assistance is subject to arrest under an outstanding warrant arising
3 from a charge of violating conditions of parole or probation or from a felony charge against that
4 applicant or recipient in any jurisdiction. This section does not affect the eligibility for
5 assistance of other members of the applicant's or recipient's household. An applicant or
6 recipient described in this section is eligible for program assistance, if all other eligibility
7 criteria of the law are met, when the applicant or recipient is no longer subject to arrest under
8 an outstanding warrant as described in this section.

9 (b) If federal approval is required in order to prevent the loss of federal reimbursement
10 as a result of the application of this section to an applicant for or recipient of program
11 assistance, the Department of Health and Human Services shall promptly take any action
12 necessary to obtain federal approval."

13 SECTION 3. Part 2 of Article 4 of Chapter 114 of the General Statutes is amended
14 by adding the following new section to read:

15 "**§ 114-19.33. Criminal record checks of applicants for or recipients of program**
16 **assistance.**

17 The Department of Justice may provide to a county department of social services from the
18 State and National Repositories of Criminal Histories the criminal history of any person who
19 applies for program assistance under Part 2 or Part 5 of Article 2 of Chapter 108A of the
20 General Statutes. The county department of social services shall provide to the Department of
21 Justice, along with the request, a form signed by the applicant or recipient acknowledging
22 receipt of the notification required by G.S. 108A-26.1(a) and any identifying information
23 required by the State and National Repositories and any additional information required by the
24 Department of Justice. Except as provided under G.S. 108A-26.1, the county department of
25 social services shall keep all information obtained pursuant to this section confidential."

26 SECTION 4. This act becomes effective July 1, 2013.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

6/26/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Sharon D Moore	DHHS/DSS
Chris Agnew	DOJ
Daniel Kolbacker	NC Board of Nursing
Teel Fitzgerald	cnc
Chris Hill	NC Justice Center
Alan Briggs	NC Food Banks
Andy Chase	KMA
Chuck Stone	SEAN
Ray Emanuel	School of Government
Dr. Duett	SOS
Thomas C. Caves, Jr.	NC SBI

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE

(Committee Name)

6/26/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

<u>NAME</u>	<u>FIRM OR AGENCY AND ADDRESS</u>
Amy White	NCHS
FLOYD BOYER	NC Respiratory Care Board
Bill Ruston	ACR
DANIEL VAN LIERE	V. DANT HEALTH
Debra Hughes	ICLG
Sarah Wolfe	MWCLLC
Jane Stevens	NCAHA / NCHA
Sharon Pearce	CAS
Andrew Cagle	NC Sheriff's Assn
Jon Carr	John Deere Law Firm
Alex Bojor	CGS
Brendan Harrison	Student
Kay Paksoy	NASW-NC
Chris Sigmund	Intern - Sen. Kinnaird
Sachi Pattnaik	Shadowing Sen. Kinnaird

**Senate Committee on Health Care
Wednesday, June 11, 2014, 11:00 AM
544 Legislative Office Building**

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 749	Strengthen Controlled Substances Monitoring.	Senator Hartsell Senator Clark

Presentations

Other Business

Adjournment

**Senate Committee on Health Care
Wednesday, June 11, 2014 at 11:00 AM
Room 544 of the Legislative Office Building**

MINUTES

The Senate Committee on Health Care met at 11:00 AM on June 11, 2014, in Room 544 of the Legislative Office Building. Fifteen members were present.

Senator Ralph Hise, Chair, presided.

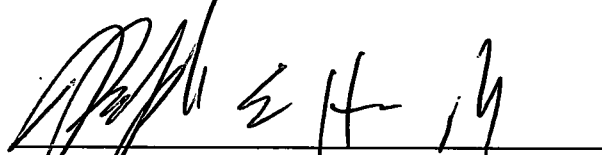
Senator Hise opened the meeting by recognizing the pages—Mackin Boylan of Wake County, Robert Edwards of Mecklenburg County, Andrew Gaddy of Orange County, Alton Gayton of Wake County, Dierdre Logan of Durham County, Marika Samuelsson of Johnston County, Maribelle Scoggin of Wake County, Eliza Parden Smith of Wilson County, Amanda Spence of Raleigh, and Matthew Stevens of Mecklenburg County; and the Sergeants-at-Arms—Anderson Meadows, Ernie Sherrell, and Matt Urben.

Senator Hise recognized Senator Hartsell and Senator Clark who both discussed Senate Bill 749 – Strengthen Controlled Substances Monitoring. Senator Hise introduced for consideration a PCS for Senate Bill 749 – Strengthen Controlled Substances Monitoring, which was approved by the Committee.

Sean Hamel, Senior Program Evaluator, Program Evaluation Division presented findings of the report – North Carolina Needs to Strengthen Its System for Monitoring and Preventing the Abuse of Prescribed Controlled Substances – for the Joint Legislative Program Evaluation Oversight Committee. He answered questions from Committee members.

Senator Pate moved for a favorable report to the PCS, unfavorable as to the original bill. The motion passed.

The meeting adjourned at 11:50 AM.



Senator Ralph Hise, Chair
Presiding



Susan Fanning, Committee Clerk

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	June 11, 2014	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 749	Strengthen Controlled Substances Monitoring.	Senator Hartsell Senator Clark

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

**NORTH CAROLINA GENERAL ASSEMBLY
SENATE**

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair

Senator Pate, Co-Chair

Wednesday, June 11, 2014

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

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

SB 749

Strengthen Controlled Substances Monitoring.

Draft Number: S749-PCS15449-RF-41

Sequential Referral: None

Recommended Referral: Appropriations/Base Budget

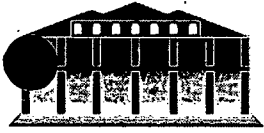
Long Title Amended: Yes

TOTAL REPORTED: 1

Senator Fletcher Hartsell will handle SB 749



* C M R 1 0 3 3 - V - 1 *



PROGRAM EVALUATION DIVISION

NORTH CAROLINA GENERAL ASSEMBLY

April 2014

Report No. 2014-05

North Carolina Needs to Strengthen Its System for Monitoring and Preventing the Abuse of Prescribed Controlled Substances

Summary

This evaluation examines the system for monitoring and preventing the abuse of prescribed controlled substances. In North Carolina, there are four mechanisms to monitor and prevent the abuse of prescribed controlled substances: the oversight of prescribers and dispensers, the prescription drug monitoring program (PDMP), Medicaid lock-in, and law enforcement.

In the area of oversight, the State would benefit from more robust prescribing guidelines and continuing education requirements for prescribers. Guidelines and continuing education are important for ensuring standards for clinical care.

The State can improve the PDMP by increasing utilization of the Controlled Substances Reporting System (CSRS) through streamlining access and removing barriers to use of CSRS data. In 2012, doctors and pharmacists used the CSRS less than 6% of the time a prescription for a controlled substance was written or dispensed. The CSRS also lacks important features for security and advanced data analysis and fails to incorporate internal controls for user access. These issues are related to the Department of Health and Human Services' (DHHS') contract for the operation of the CSRS, which has not maximized the value of limited resources.

North Carolina's ability to prevent the abuse of prescribed controlled substances is hampered by the Division of Medical Assistance's lock-in program being non-operational since July 2013, which has cost the Medicaid program an estimated \$1.3 million to \$2 million. Even when it was operational, the lock-in program suffered from shortcomings that limited its effectiveness and cost savings.

North Carolina lacks a coordinated strategy and system for monitoring and preventing the abuse of prescribed controlled substances. Several state entities participate in the system, but no single strategy exists to link goals and objectives to operations of the system's entities. Without these administrative tools, the State cannot monitor its efforts to reduce the abuse of prescribed controlled substances.

To address these findings, the General Assembly should direct state health officials to develop statewide prescribing guidelines, direct health care regulatory boards to adopt these guidelines, and require continuing education in opioid pain management for prescribers of controlled substances. In addition, the General Assembly should direct the Department of Health and Human Services to:

- modify the contract for the CSRS to improve performance, strengthen access controls, improve data security, ensure advanced analytics, and enter into a data-sharing agreement expanding analytical capacity;
- improve the effectiveness and efficiency of the Medicaid lock-in program; and
- develop a strategic plan and performance management system to monitor prescription drug abuse.



North Carolina Needs to Strengthen Its System for Monitoring and Preventing the Abuse of Prescribed Controlled Substances

A presentation to the
Senate Health Care Committee
June 11, 2014

Sean Hamel, Senior Program Evaluator

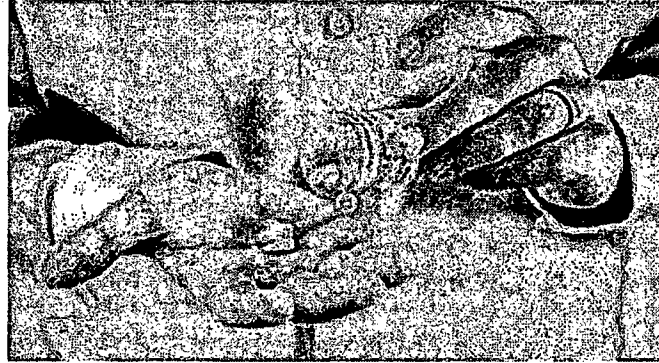


Our Charge

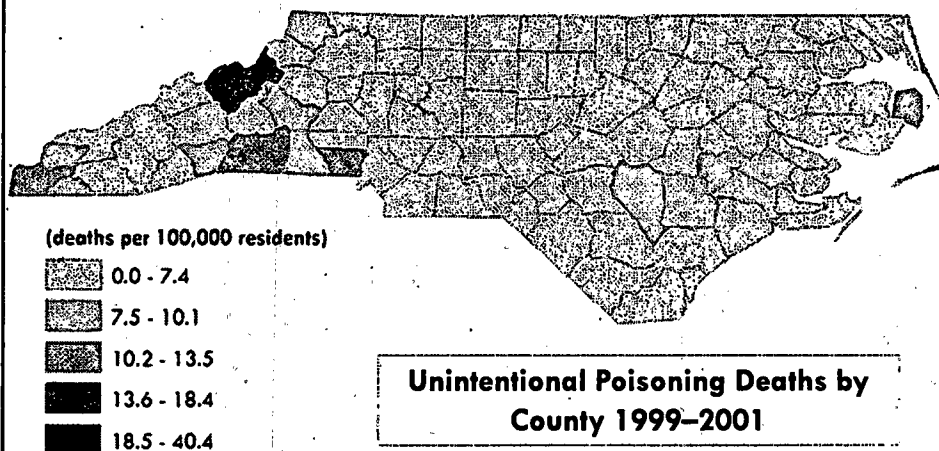
Evaluate North Carolina's system for
monitoring and preventing the abuse of
prescribed controlled substances



Background

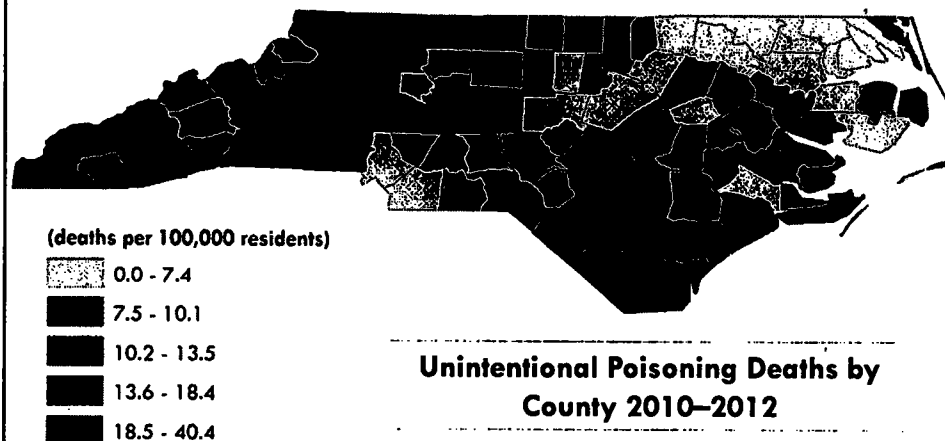


Unintentional Poisoning Deaths Have Grown by 300% Over 10 Years



Report pp. 3-4

Unintentional Poisoning Deaths Have Grown by 300% Over 10 Years



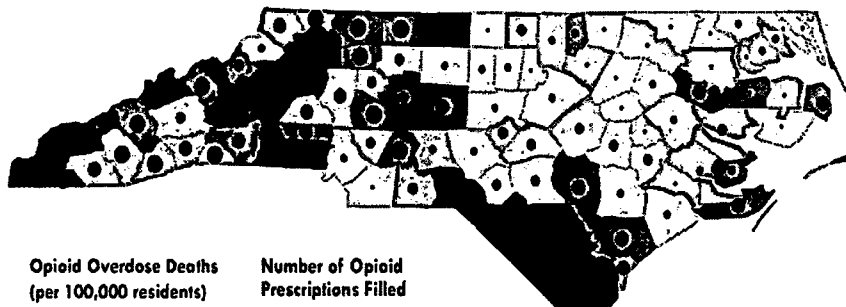
Report pp. 3-4

Controlled Substances

- Federal code and state law categorize these drugs by their potential for abuse and by the severity of their addictiveness
- Schedules include prescription drugs that have a currently accepted medical use
- Opioids, stimulants, and depressants are the most commonly abused prescribed controlled substances

Report pp.4-5

Overdose Death Rates Increase with Opioid Prescribing Volume



Opioid Overdose Deaths
(per 100,000 residents)

- 0.0 - 2.6
- 2.7 - 4.3
- 4.4 - 7.6
- 7.7 - 12.0
- 12.1 - 49.4

Number of Opioid
Prescriptions Filled
(per 100,000 residents)

- 43,800 - 72,351
- 72,352 - 88,693
- 88,694 - 100,038
- 100,039 - 114,096
- 114,097 - 150,716

Note: This exhibit reflects a two-year average of county population, opioid overdose deaths, and opioid prescribing volume between 2010 and 2011.

Report pg. 7



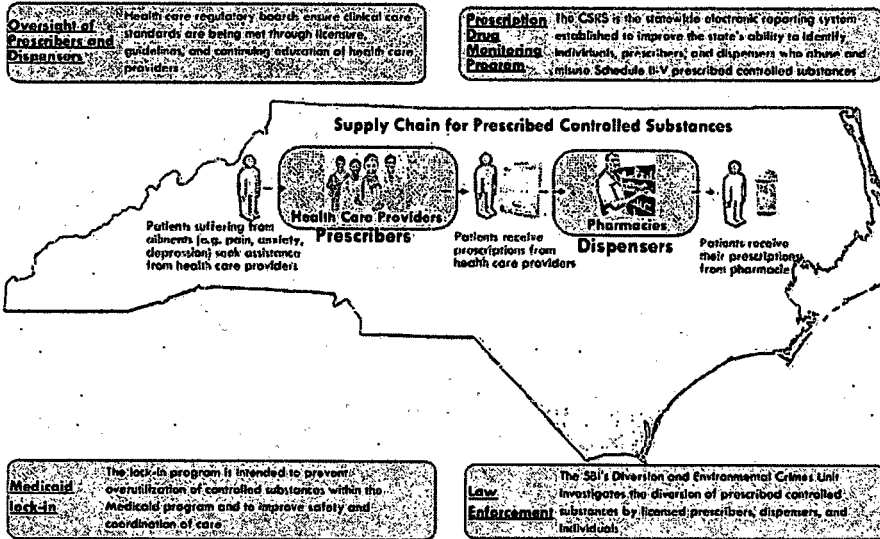
Societal Costs Associated with the Abuse of Prescribed Controlled Substance

- For every one unintentional poisoning death
 - 10 people are admitted to treatment facilities
 - 32 people are admitted to the emergency room
- Cost to public and private medical insurers nationally is estimated at \$72.5 billion per year

Report pp.4-5



System for Monitoring the Abuse of Prescribed Controlled Substances



Report pp. 10-12

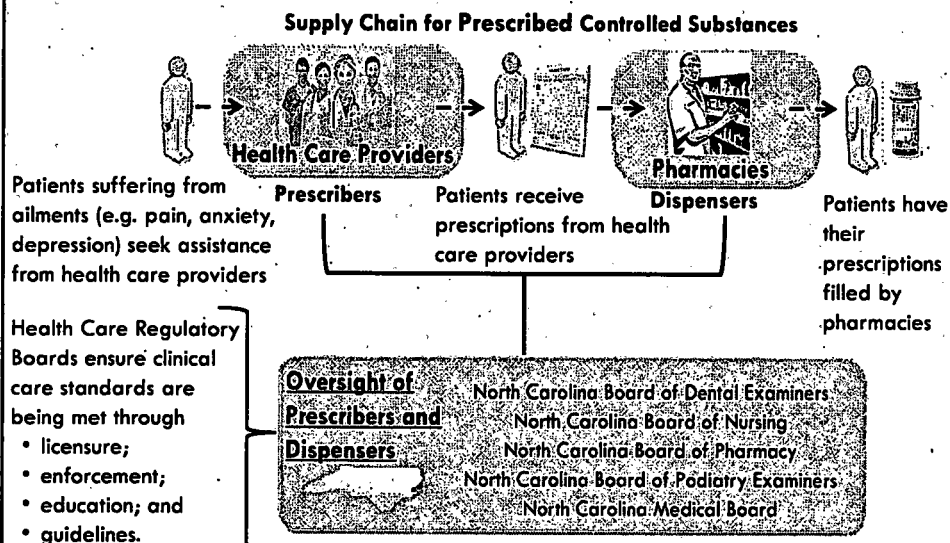
Program Evaluation Division



North Carolina General Assembly

9

Occupational Licensing Boards Regulate Prescribers and Dispensers



Report p. 13

Program Evaluation Division

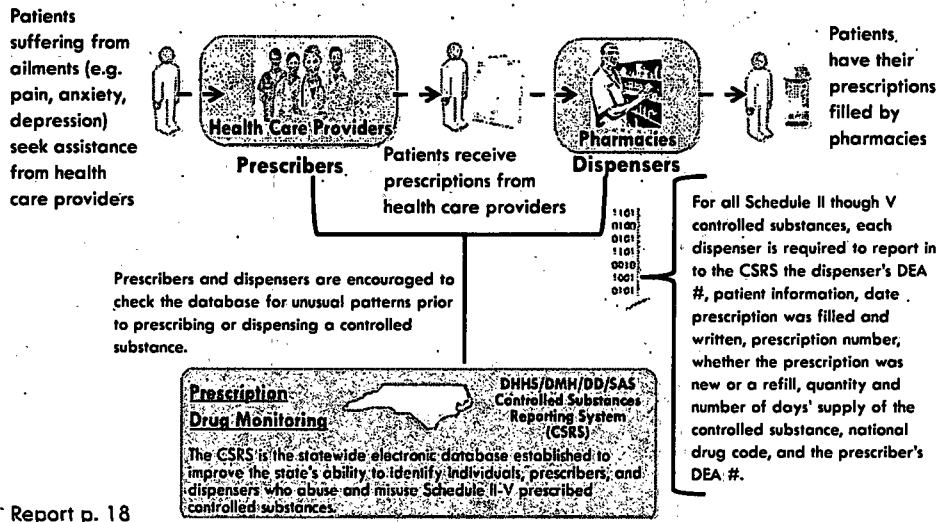


North Carolina General Assembly

10

The CSRS is a Monitoring Tool

Supply Chain for Prescribed Controlled Substances



Report p. 18

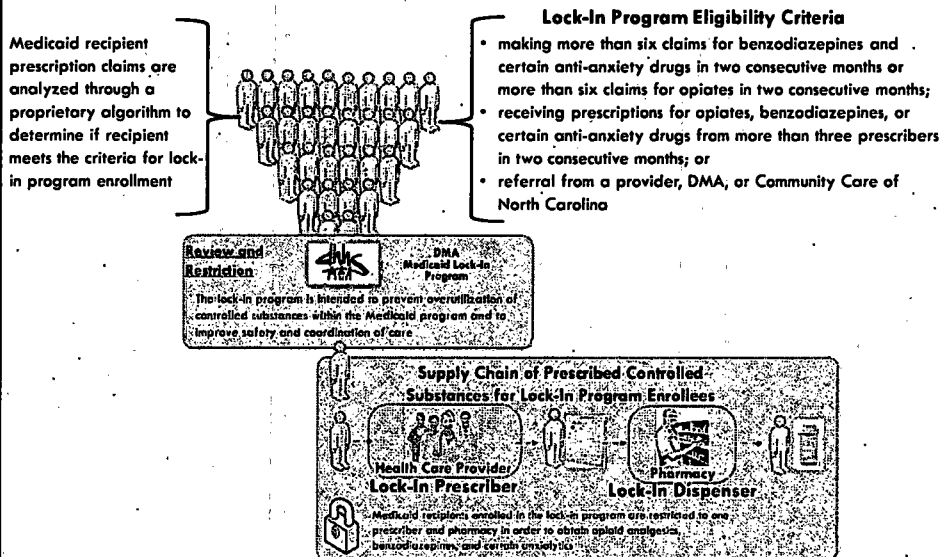
Program Evaluation Division



North Carolina General Assembly

11

Lock-in Program Modifies the Supply Chain for Select Medicaid Recipients



Report p. 16

Program Evaluation Division



North Carolina General Assembly

12

Findings



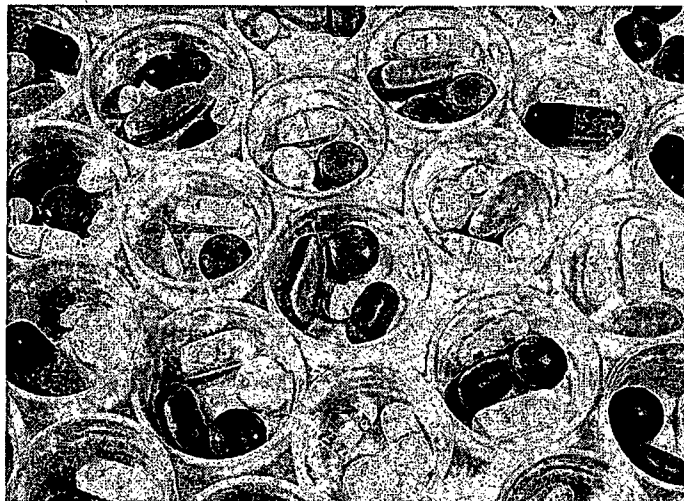
Overview of Findings

1. The State lacks adequate prescribing guidelines and continuing education requirements
2. Performance of the Department of Health and Human Services (DHHS) Controlled Substance Reporting System (CSRS) is hindered by access barriers, a lack of data connectivity, and limited analytical capacity
3. The lock-in program is non-operational, costing the Medicaid program an estimated \$1.3 million to \$2 million; even when operational, the program suffered from several shortcomings

Overview of Findings

4. The contract for the CSRS lacks important features and costs the State more for less functionality
5. There is no coordinated strategy or performance management system for monitoring the abuse of prescribed controlled substances

Recommendations





Overview of Recommendations

1. Direct state officials and occupational licensing boards to develop and adopt statewide opioid prescribing guidelines
2. Require continuing education for prescribers on the abuse of controlled substances
3. Improve CSRS access and utilization
4. Modify the contract with Health Information Designs for the CSRS to improve performance and functionality



Overview of Recommendations

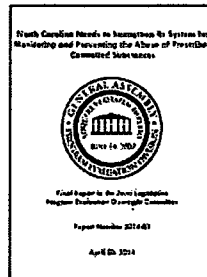
5. Expand monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System
6. Direct the Division of Medical Assistance to improve the effectiveness and efficiency of the Medicaid lock-in program
7. Establish a strategic plan and performance management system to monitor prescription drug abuse



Joint Legislative Program Evaluation Oversight Committee Action

- Briefed to our committee April 2014
- Accepted the report and directed staff to draft legislation
- *S749 Strengthen Controlled Substances Monitoring*

**Report available online at
www.ncleg.net/PED/Reports/reports.html**



Sean P. Hamel

Sean.Hamel@ncleg.net

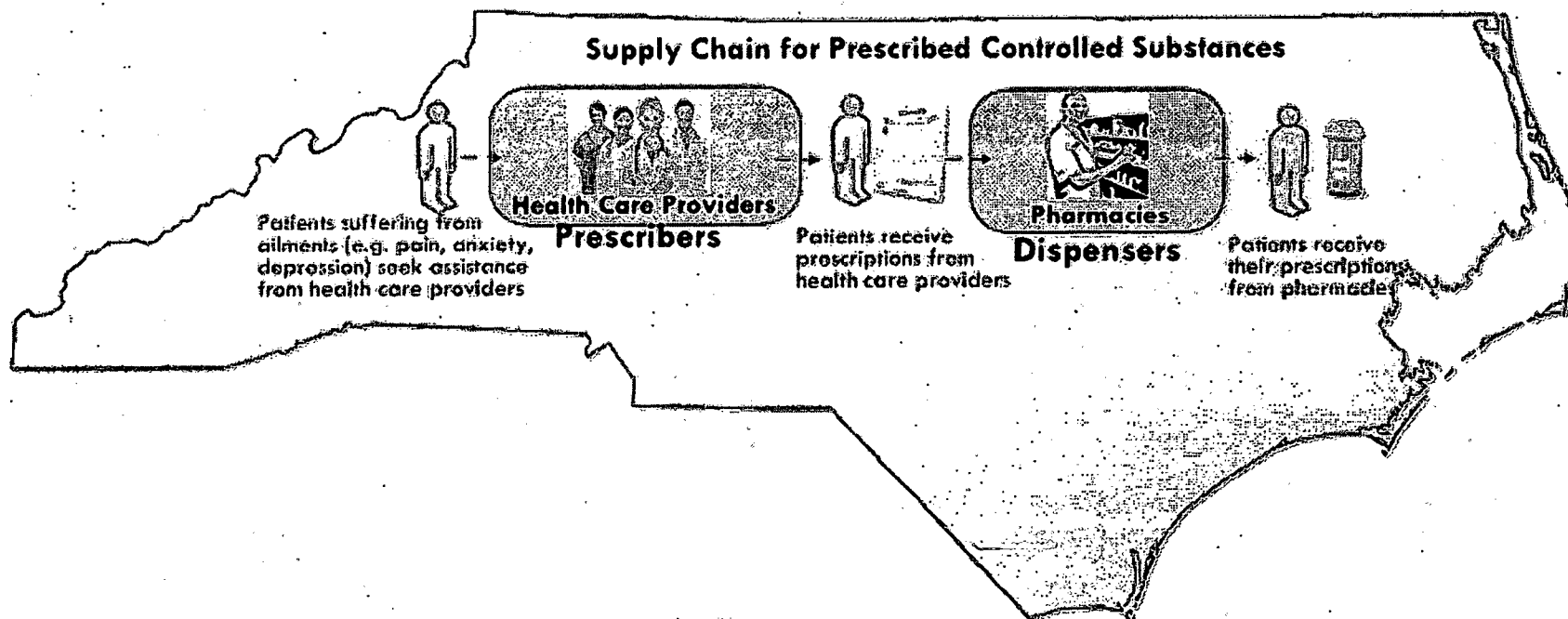
1. The Supply Chain and Mechanisms for Monitoring the Abuse of Prescribed Controlled Substances

Oversight of Prescribers and Dispensers

Health care regulatory boards ensure clinical care standards are being met through licensure, guidelines, and continuing education of health care providers.

Prescription Drug Monitoring Program

The CSRS is the statewide electronic reporting system established to improve the state's ability to identify individuals, prescribers, and dispensers who abuse and misuse Schedule II-V prescribed controlled substances.



Medicaid lock-in

The lock-in program is intended to prevent overutilization of controlled substances within the Medicaid program and to improve safety and coordination of care.

Law Enforcement

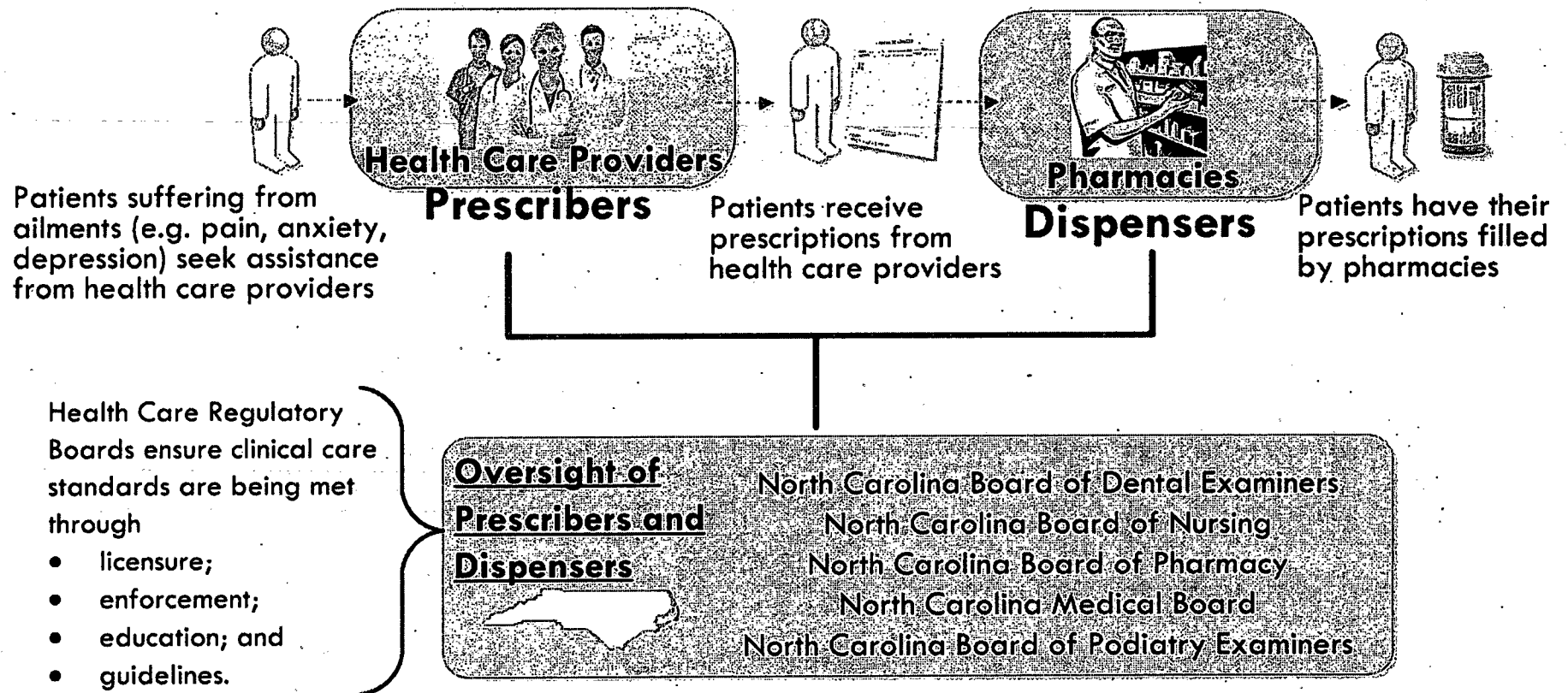
The SBI's Diversion and Environmental Crimes Unit investigates the diversion of prescribed controlled substances by licensed prescribers, dispensers, and individuals.

Note: CSRS stands for the Controlled Substances Reporting System. SBI stands for the State Bureau of Investigation.

Source: Program Evaluation Division.

2. Occupational Licensing Boards Oversee and Regulate Prescribers and Dispensers

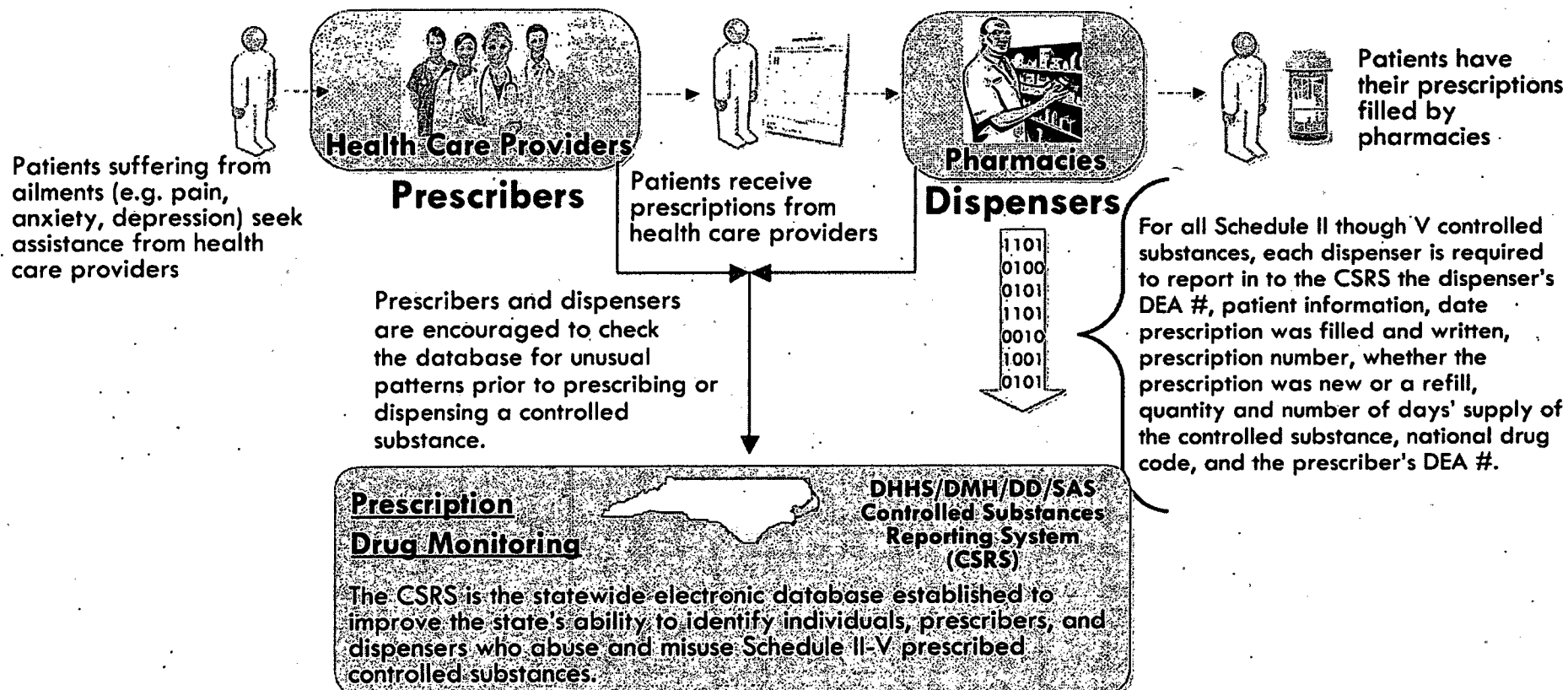
Supply Chain for Prescribed Controlled Substances



Source: Program Evaluation Division based on a review of occupational licensing board oversight.

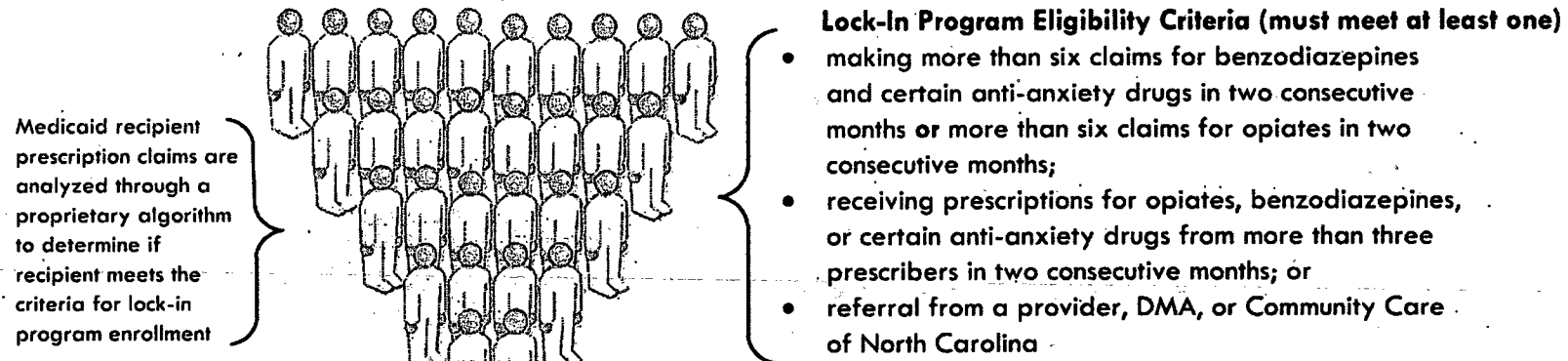
3. The CSRS is a Monitoring Tool to Observe Unusual Patterns in the Supply Chain

Supply Chain for Prescribed Controlled Substances



Source: Program Evaluation Division based on a review of CSRS operations and processes.

4. Lock-In Program Changes the Supply Chain for Prescribed Controlled Substances for Selected Medicaid Recipients.

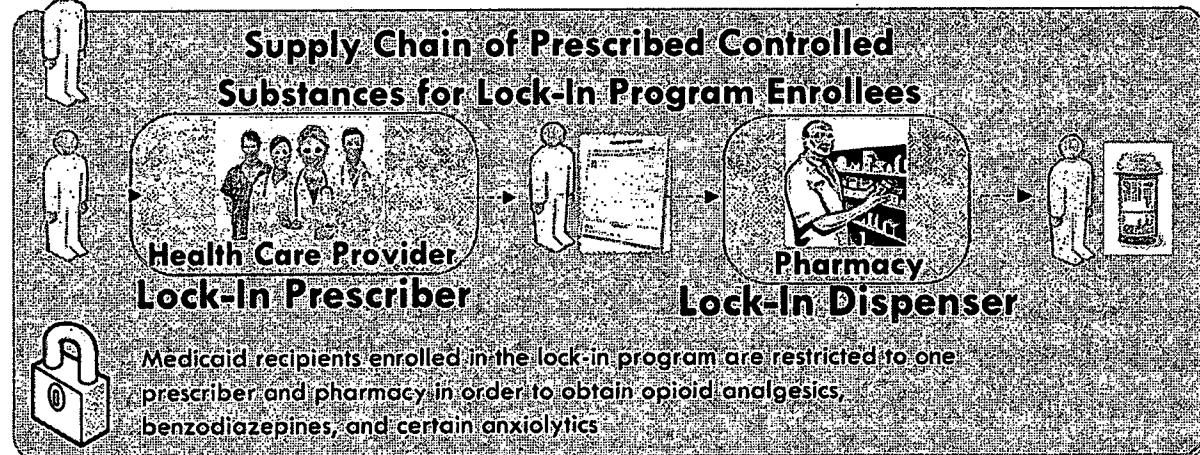


Review and Restriction



DMA Medicaid Lock-In Program

The lock-in program is intended to prevent overutilization of controlled substances within the Medicaid program and to improve safety and coordination of care





SENATE BILL 749: Strengthen Controlled Substances Monitoring

2013-2014 General Assembly

Committee: Senate Health Care
Introduced by: Sens. Hartsell, Clark
Analysis of: PCS to First Edition
S749-CSRF-41

Date: June 10, 2014
Prepared by: Barbara Riley
Committee Counsel

SUMMARY: *The Proposed Committee Substitute for Senate Bill 749 would implement the recommendations of the Program Evaluation Division's Report No. 2014-05, entitled, "North Carolina Needs to Strengthen Its System for Monitoring and Preventing the Abuse of Prescribed Controlled Substances" (April 2014). The PCS makes changes to certain provisions relating to funding, as well as some technical changes.*

[As introduced, this bill was identical to H1037, as introduced by Reps. Howard, Moffitt, Lucas, which is currently in House Health and Human Services.]

BILL ANALYSIS: House Bill 1037 would implement the recommendations of the Program Evaluation Division Report Number 2014-05. The report can be found at the following website: http://www.ncleg.net/PED/Reports/documents/Rx/Rx_Report.pdf.

Section 1 – Statewide Opioid Prescribing Guidelines.

Subsections (a) and (c) would require certain officials within the Department of Health and Human Services and the Department of Public Safety, in consultation with specified health care provider occupational licensing boards, to develop statewide opioid prescribing guidelines by December 31, 2014, and would direct the licensing boards to adopt the guidelines by July 1, 2015.

Subsection (b) directs those developing the State's prescribing guidelines to use other state and federal prescribing guidelines as models for developing and refining North Carolina's prescribing guidelines and sets forth specific requirements for the contents of those guidelines.

Section 2 – Continuing Education Requirements.

Section 2 would direct the North Carolina Board of Dental Examiners, the North Carolina Board of Nursing, the North Carolina Board of Podiatry Examiners, and the North Carolina Medical Board to require continuing education on the abuse of controlled substances, including at least one hour of coursework on specified topics, as a condition of license renewal for health care providers who prescribe controlled substances.

Section 3 – Improve Controlled substances Reporting System Access and Utilization.

Subsection (a) would amend G.S. 90-113.74 to require that data within the North Carolina Controlled Substances Reporting System (CSRS), which contains confidential information on controlled substance prescriptions, be (i) used to inform medical records and clinical care, (ii) directly accessible by the DEA, and (ii) transferred to patients' electronic medical records stored within the North Carolina Health Information Exchange (NC HIE).

Subsection (b) would require DHHS to adopt policies and to modify the CSRS contract by December 31, 2014, in order to support this expanded functionality and access.



Section 4 – Improve Controlled Substances Reporting System Contract.

Subsections (a) and (b) would require DHHS to modify its CRCS contract in order to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Seven specific improvements are listed. DHHS must report to designated legislative committees on the progress of contract modifications by November 15, 2014 and then complete the contract changes by December 31, 2014.

Subsection (c) would require DHHS to apply for grant funding for connection costs and ongoing interstate connectivity costs.

Subsection (d) would appropriate monies to DHHS from the General Fund for fiscal year 2014-2015, as follows: \$5,100 for costs of connecting the CSRS and the NC HIE and \$15,000 to maintain this connection; \$40,035 to establish the initial interface for PMP Interconnect for interstate connectivity; and \$15,000 (non-recurring) for the costs of annual service fees for interstate connectivity. The amounts appropriated for the initial and service costs for interstate connectivity shall be adjusted if DHHS obtains funds for this purpose from other sources.

Section 5 – Expand Monitoring Capacity.

Section 5 would require the CSRS to expand its monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System (PBSS) and direct the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of DHHS to report to legislative committees as specified on its participation in the PBSS.

Section 6 – Medicaid Lock-in Program.

Section 6 would require several listed modifications to DMA's existing Medicaid lock-in program, and would require DMA to provide an implementation report to the Joint Legislative Program Evaluation Oversight Committee by September 30, 2014. (The Medicaid Lock-in Program may restrict a Medicaid recipient to the use of one pharmacy and/or one physician to ensure proper management of the recipient's medication use.)

Section 7 – Statewide Strategic Plan.

Subsection (a) would establish in DHHS the Prescription Drug Abuse Advisory Committee, comprised of representatives of various agencies, programs, entities and individuals that work towards reducing prescription drug abuse, to be tasked with developing and implementing a statewide strategic plan to combat the problem of prescription drug abuse and then monitoring the implementation of the plan.

Subsections (b), (c) and (d) specify steps the Committee must complete in developing the plan, and require the plan to include three to five strategic goals, connected with listed system objectives, that are outcome-oriented and measurable. DHHS and the Committee would be directed to collaborate to develop a formalized performance management system that connects the goals and objectives identified in the plan to operations of the CSRS and Medicaid lock-in program, oversight of prescribers and dispensers, and certain law enforcement activities.

Subsection (e) would require DHHS to submit an annual report, beginning December 1, 2015, on the performance of the prescription drug abuse monitoring system to specified committees of the General Assembly.

EFFECTIVE DATE: The bill would be effective when it becomes law.

Jan Paul, Counsel to House Health and Human Services, and Ryan Blackledge, Legislative Bill Drafting Division, substantially contributed to this summary.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

D

**SENATE BILL 749*
PROPOSED COMMITTEE SUBSTITUTE S749-CSRF-41 [v.3]**

6/10/2014 3:58:21 PM

Short Title: Strengthen Controlled Substances Monitoring.

(Public)

Sponsors:

Referred to:

May 15, 2014

A BILL TO BE ENTITLED
AN ACT TO STRENGTHEN THE MONITORING OF CONTROLLED SUBSTANCES.
The General Assembly of North Carolina enacts:

SECTION 1. Statewide Opioid Prescribing Guidelines.

(a) The following State health officials and health care provider licensing boards shall develop statewide opioid prescribing guidelines that the health care provider occupational licensing boards shall then adopt:

- (1) The Director of the Division of Public Health of the Department of Health and Human Services (DHHS).
- (2) The Director of the Division of Medical Assistance, DHHS.
- (3) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.
- (4) The directors of medical, dental, and mental health services within the Department of Public Safety.
- (5) North Carolina State Board of Dental Examiners.
- (6) North Carolina Board of Nursing.
- (7) North Carolina Board of Podiatry Examiners.
- (8) North Carolina Medical Board.

(b) In developing statewide opioid prescribing guidelines, other state and federal prescribing guidelines shall serve as models to develop and refine North Carolina's prescribing guidelines. Developers of the guidelines also shall consider establishing opioid dosage thresholds for physician consultation. The guidelines shall be developed based on the criteria for clinical practice guidelines set forth by the Institute of Medicine of the National Academies and shall do all of the following:

- (1) Make recommendations for clinical actions based on review of empirical evidence.
- (2) Rate the strength of each clinical recommendation.
- (3) Rate the quality of evidence used to support recommendations for clinical action.
- (4) Explain and assess the benefits and harms associated with options for alternative treatments.

(c) The statewide prescribing guidelines shall be completed by December 31, 2014. The health care provider occupational licensing boards listed in subsection (a) of this section shall adopt the opioid prescribing guidelines by no later than July 1, 2015.



* S 7 4 9 - C S R F - 4 1 - V - 3 *

SECTION 2. Continuing Education Requirements.

(a) The following health care provider occupational licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

- (1) North Carolina Board of Dental Examiners.
- (2) North Carolina Board of Nursing.
- (3) North Carolina Board of Podiatry Examiners.
- (4) North Carolina Medical Board.

(b) In establishing the continuing education standards, the boards listed in subsection (a) of this section shall require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices. The course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management.

SECTION 3. Improve Controlled Substances Reporting System Access and Utilization.

(a) G.S. 90-113.74 reads as rewritten:

"§ 90-113.74. Confidentiality.

(a) Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used (i) for investigative or evidentiary purposes related to violations of State or federal law and law, (ii) for regulatory activities, activities, or (iii) to inform medical records and clinical care. Except as otherwise provided by this section, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

- (8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.
- (9) The federal Drug Enforcement Administration's Office of Diversion Control.
- (10) The North Carolina Health Information Exchange (NC HIE), established under Article 29A of this Chapter, through web-service calls.

...."

(b) The Department of Health and Human Services shall adopt appropriate policies and procedures documenting and supporting the additional functionality and expanded access added by subsection (a) of this section for the Controlled Substances Reporting System (CSRS) for the entities added to G.S. 90-113.74(c) by subsection (a) of this section, and shall amend its contract with the vendor that operates the CSRS to support the additional functionality and expanded access to the CSRS.

SECTION 4. Improve Controlled Substances Reporting System Contract.

(a) The Department of Health and Human Services (DHHS) shall modify the contract for the Controlled Substances Reporting System (CSRS) to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Specifically, the contract shall be modified to include the following:

- (1) A connection to the North Carolina Health Information Exchange (NC HIE).

- (2) The establishment of interstate connectivity. DHHS shall execute a memorandum of understanding with the National Association of Boards of Pharmacy to participate in PMP InterConnect.
- (3) A system feature requiring users to update account information annually.
- (4) Confirmation of prescriber number validity by cross-referencing CSRS users with DEA numbers to ensure access is limited to users with valid, up-to-date information.
- (5) Data security protocols that meet or exceed the Federal Information Processing Standards (FIPS) established by the National Institute of Standards and Technology (NIST).
- (6) The quarterly transfer of a copy of the complete CSRS database to DHHS. Transferred data must be encrypted, include identified and deidentified cases, and be conducted through standard file transfer protocol.
- (7) Up to five ad-hoc reports per month from the contractor that DHHS staff cannot produce through the online system.

(b) DHHS shall complete the contract modifications required by subsection (a) of this section by December 31, 2014. DHHS shall report by November 15, 2014, to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services regarding the progress to modify the contract.

(c) DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect. The Department shall request \$40,035 to establish the initial interface for PMP InterConnect and \$30,000 for two years of ongoing service, maintenance and support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (a) of this section.

(d) In order to support certain requirements of subsection (a) of this section, the following appropriations are made from the General Fund to DHHS:

- (1) Five thousand one hundred dollars (\$5,100) for fiscal year 2014-2015 for the purpose of connecting the CSRS and the NC HIE, as required by subdivision (1) of subsection (a) of this section.
- (2) The sum of fifteen thousand dollars (\$15,000) for fiscal year 2014-2015, recurring, for the cost of maintaining a connection between the CSRS and the NC HIE, as required by subdivision (1) of subsection (a) of this section.
- (3) The sum of forty thousand thirty five dollars (\$40,035) for fiscal year 2014-2015 to establish the initial interface for PMP InterConnect as required by subdivision (2) of subsection (a) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this non-recurring appropriation shall revert to the General Fund.
- (4) The sum of fifteen thousand dollars (\$15,000) for fiscal year 2014-2015, non-recurring, for the cost of annual service fees for the interstate connection for the drug monitoring program, as required by subdivision (2) of subsection (a) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this non-recurring appropriation shall revert to the General Fund.

SECTION 5. Expand Monitoring Capacity.

(a) The North Carolina Controlled Substances Reporting System shall expand its monitoring capacity by establishing data use agreements with the Prescription Behavior

1 Surveillance System. In order to participate, the CSRS shall establish a data use agreement with
2 the Center of Excellence at Brandeis University no later than January 1, 2015.

3 (b) Beginning September 1, 2015, and every two years thereafter, the Division of Mental
4 Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health
5 and Human Services, shall report on its participation with the Prescription Behavior
6 Surveillance System to the Joint Legislative Oversight Committee on Health and Human
7 Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

8 **SECTION 6. Medicaid Lock-in Program.**

9 The Division of Medical Assistance of the Department of Health and Human Services
10 (DMA) shall take the following steps to improve the effectiveness and efficiency of the
11 Medicaid lock-in program:

- 12 (1) Establish written procedures for the operation of the lock-in program,
13 including specifying the responsibilities of DMA and the program
14 contractor.
- 15 (2) Establish procedures for the sharing of bulk data with the Controlled
16 Substances Regulatory Branch.
- 17 (3) In consultation with the Physicians Advisory Group, extend lock-in duration
18 to two years and revise program eligibility criteria to align the program with
19 the statewide strategic goals for preventing prescription drug abuse. DMA
20 shall report an estimate of the cost-savings from the revisions to the
21 eligibility criteria to the Joint Legislative Program Evaluation Oversight
22 Committee and the Joint Legislative Oversight Committee on Health and
23 Human Services within one year of the lock-in program again becoming
24 operational.
- 25 (4) Develop a Web site and communication materials to inform lock-in
26 enrollees, prescribers, pharmacists, and emergency room health care
27 providers about the program.
- 28 (5) Increase program capacity to ensure that all individuals who meet program
29 criteria are locked-in.
- 30 (6) Conduct an audit of the lock-in program within six months of the lock-in
31 program again becoming operational in order to evaluate the effectiveness of
32 program restrictions in preventing overutilization of controlled substances,
33 identifying any program vulnerabilities, and addressing whether there is
34 evidence of any fraud or abuse within the program.

35 DMA shall report to the Joint Legislative Program Evaluation Oversight Committee by
36 September 30, 2014, on its progress towards implementing all items included in this section.

37 **SECTION 7. Statewide Strategic Plan.**

38 (a) There is hereby created the Prescription Drug Abuse Advisory Committee, to be housed
39 in and staffed by the Department of Health and Human Services (DHHS). The Committee shall
40 develop and, through its members, implement a statewide strategic plan to combat the problem
41 of prescription drug abuse. The Committee shall include representatives from the following, as
42 well as any other persons designated by the Secretary of Health and Human Services:

- 43 (1) The Division of Medical Assistance, DHHS.
- 44 (2) The Division of Mental Health, Developmental Disabilities, and Substance
45 Abuse Services, DHHS.
- 46 (3) The Division of Public Health, DHHS.
- 47 (4) The Office of Rural Health and Community Care, DHHS.
- 48 (5) The State Bureau of Investigation.
- 49 (6) The Attorney General's Office.
- 50 (7) The following health care regulatory boards with oversight of prescribers
51 and dispensers of prescription drugs:

- a. North Carolina Board of Dental Examiners.
- b. North Carolina Board of Nursing.
- c. North Carolina Board of Podiatry Examiners.
- d. North Carolina Medical Board.
- e. North Carolina Board of Pharmacy.
- (8) The UNC Injury Prevention Research Center.
- (9) The substance abuse treatment community.
- (10) Community Care of North Carolina's (CCNC's) Project Lazarus.
- (11) Governor's Institute on Substance Abuse, Inc.
- (12) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

(b) In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:

- (1) Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.
- (2) Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).
- (3) Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).
- (4) Identify strategic issues based on SWOC and GAP analyses.
- (5) Formulate strategies and resources for addressing these issues.

(c) The strategic plan for reducing prescription drug abuse shall include three to five strategic goals that are outcome-oriented and measureable. Each goal must be connected with objectives supported by the following four mechanisms of the system:

- (1) Oversight and regulation of prescribers and dispensers by state health care regulatory boards.
- (2) Operation of the Controlled Substances Reporting System.
- (3) Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.
- (4) Enforcement of state laws for the misuse and diversion of controlled substances.
- (5) Any other appropriate mechanism identified by the Committee.

(d) DHHS, in consultation with the Prescription Drug Abuse Advisory Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress towards achieving goals and objectives and must recommend actions to be taken when performance falls short.

(e) Beginning on December 1, 2015, and annually thereafter, DHHS shall submit an annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 8. This act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

1

SENATE BILL 749*

Short Title: Strengthen Controlled Substances Monitoring. (Public)

Sponsors: Senators Hartsell, Clark (Primary Sponsors); and Tarte.

Referred to: Health Care.

May 15, 2014

**A BILL TO BE ENTITLED
AN ACT TO STRENGTHEN THE MONITORING OF CONTROLLED SUBSTANCES, AS
RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION
OVERSIGHT COMMITTEE.**

The General Assembly of North Carolina enacts:

SECTION 1. Statewide Opioid Prescribing Guidelines. – (a) The following State health officials and health care provider licensing boards shall develop statewide opioid prescribing guidelines that the health care provider licensing boards shall then adopt:

- (1) The State Health Director.
- (2) The Director of Medical Assistance.
- (3) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
- (4) The directors of medical, dental, and mental health services within the Department of Public Safety.
- (5) North Carolina Board of Dental Examiners.
- (6) North Carolina Board of Nursing.
- (7) North Carolina Board of Podiatry Examiners.
- (8) North Carolina Medical Board.

SECTION 1.(b) Other state and federal prescribing guidelines should serve as models to develop and refine North Carolina's prescribing guidelines. The development of the guidelines should consider use of opioid dosage thresholds for physician consultation. The guidelines must be developed based on the criteria for clinical practice guidelines set forth by the Institute of Medicine of the National Academies and must do all of the following:

- (1) Make recommendations for clinical actions based on review of empirical evidence.
- (2) Rate the strength of each clinical recommendation.
- (3) Rate the quality of evidence used to support recommendations for clinical action.
- (4) Explain and assess the benefits and harms associated with options for alternative treatments.

SECTION 1.(c) The statewide prescribing guidelines shall be completed by December 31, 2014. The health care provider occupational licensing boards listed in subsection (a) of this section shall adopt the opioid prescribing guidelines by no later than July 1, 2015.

SECTION 2. Continuing Education Requirements. – (a) The following health care provider occupational licensing boards shall require continuing education on the abuse of



controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

- (1) North Carolina Board of Dental Examiners.
- (2) North Carolina Board of Nursing.
- (3) North Carolina Board of Podiatry Examiners.
- (4) North Carolina Medical Board.

SECTION 2.(b) In establishing the continuing education standards, the boards listed in subsection (a) of this section shall require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices. The course must include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management.

SECTION 3. Improve CSRC Access and Utilization. – (a) G.S. 90-113.74 reads as rewritten:

"§ 90-113.74. Confidentiality.

(a) Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used (i) for investigative or evidentiary purposes related to violations of State or federal law and law, (ii) for regulatory activities, activities, or (iii) to inform medical records and clinical care. Except as otherwise provided by this section, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

...

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

...

- (8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.
- (9) The federal Drug Enforcement Administration's Office of Diversion Control.
- (10) The North Carolina Health Information Exchange (NC HIE), established under Article 29A of this Chapter, through web-service calls.

...."

SECTION 3.(b) The Department of Health and Human Services (DHHS) shall adopt appropriate policies and procedures documenting and supporting the additional functionality and expanded access added by subsection (a) of this section for the North Carolina Controlled Substances Reporting System (CSRS) for the entities added to G.S. 90-113.74(c) by subsection (a) of this section, as well as amend its contract with the vendor that operates the CSRS to support the additional functionality and expanded access to the CSRS.

SECTION 4. Improve CSRS Contract. – (a) The Department of Health and Human Services (DHHS) shall modify the contract for the Controlled Substances Reporting System (CSRS) to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Specifically, the contract shall be modified to include the following:

- (1) A connection to the North Carolina Health Information Exchange (NC HIE).
- (2) Interstate connectivity with South Carolina, Tennessee, and Virginia. The Department shall establish an interstate data sharing compact with those states.
- (3) A system feature requiring users to update account information annually.

- (4) Validation of prescriber number validation by cross-referencing CSRS users with DEA numbers to ensure access is limited to users with valid, up-to-date information.
- (5) Data security protocols that meet or exceed the Federal Information Processing Standards (FIPS) established by the National Institute of Standards and Technology (NIST).
- (6) The quarterly transfer of a copy of the complete CSRS database to DHHS. Transferred data must be encrypted, include identified and deidentified cases, and be conducted through standard file transfer protocol.
- (7) Up to five ad-hoc reports per month from the contractor that DHHS staff cannot produce through the online system.

SECTION 4.(b) The Department of Health and Human Services shall complete the contract modifications required by subsection (a) of this section by December 31, 2014. The Department shall report by November 15, 2014, to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services regarding the progress to modify the contract.

SECTION 4.(c) The Department of Health and Human Services shall use forty thousand thirty-five dollars (\$40,035) of existing grant funding from the federal Harold Rogers Prescription Drug Monitoring Program for fiscal year 2014-2015 for the purpose of creating a connection to the RxCheck Hub in order to create interstate connectivity for the drug monitoring program, as required by subdivision (2) of subsection (a) of this section.

SECTION 4.(d) In order to support certain requirements of subsection (a) of this section, the following appropriations are made from the General Fund to the Department of Health and Human Services:

- (1) Five thousand one hundred dollars (\$5,100) for fiscal year 2014-2015 for the purpose of connecting the Controlled Substances Reporting System (CSRS) and the North Carolina Health Information Exchange (NC HIE), as required by subdivision (1) of subsection (a) of this section.
- (2) The sum of fifteen thousand dollars (\$15,000) for fiscal year 2014-2015, recurring, for the cost of maintaining a connection between the Controlled Substances Reporting System (CSRS) and the North Carolina Health Information Exchange (NC HIE), as required by subdivision (1) of subsection (a) of this section.
- (3) The sum of ten thousand dollars (\$10,000) for fiscal year 2014-2015, recurring, for the cost of annual service fees for the interstate connection for the drug monitoring program, as required by subdivision (2) of subsection (a) of this section.

SECTION 4.(e) The Department of Health and Human Services shall seek grant funding from the federal Harold Rogers Prescription Drug Monitoring Program or any other available grant funds to offset the cost of providing interstate connectivity for the Controlled Substances Reporting System (CSRS), which is required by subdivision (2) of subsection (a) of this section. If successful in acquiring a grant, the Department shall inform the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 5. Expand Monitoring Capacity. – (a) The North Carolina Controlled Substances Reporting System shall expand its monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System. In order to participate, the Reporting System shall establish data use agreement with the Center of Excellence at Brandeis University no later than January 1, 2015.

SECTION 5.(b) Beginning September 1, 2015, and every two years thereafter, the Department of Health and Human Services, Division of Mental Health, Developmental

1 Disabilities, and Substance Abuse Services, shall report on its participation with the
2 Prescription Behavior Surveillance System to the Joint Legislative Oversight Committee on
3 Health and Human Services and the Joint Legislative Oversight Committee on Justice and
4 Public Safety.

5 **SECTION 6. Medicaid Lock-in Program.** – The Department of Health and Human
6 Services, Division of Medical Assistance (DMA), shall take the following steps to improve the
7 effectiveness and efficiency of the Medicaid lock-in program:

- 8 (1) Establish written procedures for the operation of the lock-in program,
9 including specifying the responsibilities of DMA and the program
10 contractor.
- 11 (2) Establish procedures for the sharing of bulk data with the Controlled
12 Substances Regulatory Branch.
- 13 (3) In consultation with the Physicians Advisory Group, extend lock-in duration
14 to two years and revise program eligibility criteria to align the program with
15 the statewide strategic goals for preventing prescription drug abuse. DMA
16 shall report an estimate of the cost-savings from the revisions to the
17 eligibility criteria to the Joint Legislative Program Evaluation Oversight
18 Committee and the Joint Legislative Oversight Committee on Health and
19 Human Services within one year of the lock-in program again becoming
20 operational.
- 21 (4) Develop a Web site and communication materials to inform lock-in
22 enrollees, prescribers, pharmacists, and emergency room health care
23 providers about the program.
- 24 (5) Increase program capacity to ensure that all individuals who meet program
25 criteria are locked-in.
- 26 (6) Conduct an audit of the lock-in program within six months of the lock-in
27 program again becoming operational in order to evaluate the effectiveness of
28 program restrictions in preventing overutilization of controlled substances,
29 identifying any program vulnerabilities, and addressing whether there is
30 evidence of any fraud or abuse within the program.

31 The Department of Health and Human Services, Division of Medical Assistance, shall report to
32 the Joint Legislative Program Evaluation Oversight Committee by September 30, 2014, on its
33 progress towards implementing all items included in this section.

34 **SECTION 7. Statewide Strategic Plan.** – (a) There is hereby created the
35 Prescription Drug Abuse Advisory Committee, to be housed in and staffed by the Department
36 of Health and Human Services. The Committee shall develop and, through its members,
37 implement a statewide strategic plan to combat the problem of prescription drug abuse. The
38 Committee shall include representatives from the following, as well as any other persons
39 designated by the Secretary of Health and Human Services:

- 40 (1) The Division of Medical Assistance.
- 41 (2) The Division of Mental Health, Developmental Disabilities, and Substance
42 Abuse.
- 43 (3) The Division of Public Health.
- 44 (4) The Office of Rural Health and Community Care.
- 45 (5) The State Bureau of Investigation.
- 46 (6) The Attorney General's office.
- 47 (7) The following health care regulatory boards with oversight of prescribers
48 and dispensers of prescription drugs:
 - 49 a. North Carolina Board of Dental Examiners.
 - 50 b. North Carolina Board of Nursing.
 - 51 c. North Carolina Board of Podiatry Examiners.

- d. North Carolina Medical Board.
- (8) The UNC Injury Prevention Research Center.
- (9) The substance abuse treatment community.
- (10) Community Care of North Carolina's (CCNC's) Project Lazarus.
- (11) Governor's Institute on Substance Abuse, Inc.
- (12) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

SECTION 7.(b) In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:

- (1) Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.
- (2) Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).
- (3) Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).
- (4) Identify strategic issues based on SWOC and GAP analyses.
- (5) Formulate strategies and resources for addressing these issues.

SECTION 7.(c) The strategic plan for reducing prescription drug abuse shall include three to five strategic goals that are outcome-oriented and measureable. Each goal must be connected with objectives supported by the following four mechanisms of the system:

- (1) Oversight and regulation of prescribers and dispensers by state health care regulatory boards.
- (2) Operation of the Controlled Substances Reporting System.
- (3) Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.
- (4) Enforcement of state laws for the misuse and diversion of controlled substances.
- (5) Any other appropriate mechanism identified by the Committee.

SECTION 7.(d) The Department of Health and Human Services, in consultation with the Prescription Drug Abuse Advisory Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress towards achieving goals and objectives and must recommend actions to be taken when performance falls short.

SECTION 7.(e) Beginning on December 1, 2015, and annually thereafter, the Department of Health and Human Services shall submit an annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 8. Effective Dates. – Except as otherwise provided, this act is effective when it becomes law.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013**

S

D

**SENATE BILL 749*
PROPOSED COMMITTEE SUBSTITUTE S749-PCS15449-RF-41**

Short Title: Strengthen Controlled Substances Monitoring.

(Public)

Sponsors:

Referred to:

May 15, 2014

**A BILL TO BE ENTITLED
AN ACT TO STRENGTHEN THE MONITORING OF CONTROLLED SUBSTANCES.**

The General Assembly of North Carolina enacts:

SECTION 1. Statewide Opioid Prescribing Guidelines.

(a) The following State health officials and health care provider licensing boards shall develop statewide opioid prescribing guidelines that the health care provider occupational licensing boards shall then adopt:

- (1) The Director of the Division of Public Health of the Department of Health and Human Services (DHHS).
- (2) The Director of the Division of Medical Assistance, DHHS.
- (3) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.
- (4) The directors of medical, dental, and mental health services within the Department of Public Safety.
- (5) North Carolina State Board of Dental Examiners.
- (6) North Carolina Board of Nursing.
- (7) North Carolina Board of Podiatry Examiners.
- (8) North Carolina Medical Board.

(b) In developing statewide opioid prescribing guidelines, other state and federal prescribing guidelines shall serve as models to develop and refine North Carolina's prescribing guidelines. Developers of the guidelines also shall consider establishing opioid dosage thresholds for physician consultation. The guidelines shall be developed based on the criteria for clinical practice guidelines set forth by the Institute of Medicine of the National Academies and shall do all of the following:

- (1) Make recommendations for clinical actions based on review of empirical evidence.
- (2) Rate the strength of each clinical recommendation.
- (3) Rate the quality of evidence used to support recommendations for clinical action.
- (4) Explain and assess the benefits and harms associated with options for alternative treatments.

(c) The statewide prescribing guidelines shall be completed by December 31, 2014. The health care provider occupational licensing boards listed in subsection (a) of this section shall adopt the opioid prescribing guidelines by no later than July 1, 2015.

SECTION 2. Continuing Education Requirements.



* S 7 4 9 - P C S 1 5 4 4 9 - R F - 4 1 *

(a) The following health care provider occupational licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

- (1) North Carolina Board of Dental Examiners.
- (2) North Carolina Board of Nursing.
- (3) North Carolina Board of Podiatry Examiners.
- (4) North Carolina Medical Board.

(b) In establishing the continuing education standards, the boards listed in subsection (a) of this section shall require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices. The course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management.

SECTION 3. Improve Controlled Substances Reporting System Access and Utilization.

(a) G.S. 90-113.74 reads as rewritten:

"§ 90-113.74. Confidentiality.

(a) Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used (i) for investigative or evidentiary purposes related to violations of State or federal law and law, (ii) for regulatory activities, activities, or (iii) to inform medical records and clinical care. Except as otherwise provided by this section, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

...

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

...

- (8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.
- (9) The federal Drug Enforcement Administration's Office of Diversion Control.
- (10) The North Carolina Health Information Exchange (NC HIE), established under Article 29A of this Chapter, through Web-service calls.

...."

(b) The Department of Health and Human Services shall adopt appropriate policies and procedures documenting and supporting the additional functionality and expanded access added by subsection (a) of this section for the Controlled Substances Reporting System (CSRS) for the entities added to G.S. 90-113.74(c) by subsection (a) of this section and shall amend its contract with the vendor that operates the CSRS to support the additional functionality and expanded access to the CSRS.

SECTION 4. Improve Controlled Substances Reporting System Contract.

(a) The Department of Health and Human Services (DHHS) shall modify the contract for the Controlled Substances Reporting System (CSRS) to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Specifically, the contract shall be modified to include the following:

- (1) A connection to the North Carolina Health Information Exchange (NC HIE).
- (2) The establishment of interstate connectivity. DHHS shall execute a memorandum of understanding with the National Association of Boards of Pharmacy to participate in PMP InterConnect.
- (3) A system feature requiring users to update account information annually.

- (4) Confirmation of prescriber number validity by cross-referencing CSRS users with DEA numbers to ensure access is limited to users with valid, up-to-date information.
 - (5) Data security protocols that meet or exceed the Federal Information Processing Standards (FIPS) established by the National Institute of Standards and Technology (NIST).
 - (6) The quarterly transfer of a copy of the complete CSRS database to DHHS. Transferred data must be encrypted, include identified and deidentified cases, and be conducted through standard file transfer protocol.
 - (7) Up to five ad hoc reports per month from the contractor that DHHS staff cannot produce through the online system.
- (b) DHHS shall complete the contract modifications required by subsection (a) of this section by December 31, 2014. DHHS shall report by November 15, 2014, to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services regarding the progress to modify the contract.
- (c) DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect. The Department shall request forty-thousand thirty-five dollars (\$40,035) to establish the initial interface for PMP InterConnect and thirty thousand dollars (\$30,000) for two years of ongoing service, maintenance and support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (a) of this section.
- (d) In order to support certain requirements of subsection (a) of this section, the following appropriations are made from the General Fund to DHHS:
- (1) Five thousand one hundred dollars (\$5,100) for fiscal year 2014-2015 for the purpose of connecting the CSRS and the NC HIE, as required by subdivision (1) of subsection (a) of this section.
 - (2) The sum of fifteen thousand dollars (\$15,000) for fiscal year 2014-2015, recurring, for the cost of maintaining a connection between the CSRS and the NC HIE, as required by subdivision (1) of subsection (a) of this section.
 - (3) The sum of forty thousand thirty five dollars (\$40,035) for fiscal year 2014-2015 to establish the initial interface for PMP InterConnect as required by subdivision (2) of subsection (a) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.
 - (4) The sum of fifteen thousand dollars (\$15,000) for fiscal year 2014-2015, nonrecurring, for the cost of annual service fees for the interstate connection for the drug monitoring program, as required by subdivision (2) of subsection (a) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.

SECTION 5. Expand Monitoring Capacity.

(a) The North Carolina Controlled Substances Reporting System shall expand its monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System. In order to participate, the CSRS shall establish a data use agreement with the Center of Excellence at Brandeis University no later than January 1, 2015.

(b) Beginning September 1, 2015, and every two years thereafter, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall report on its participation with the Prescription Behavior

1 Surveillance System to the Joint Legislative Oversight Committee on Health and Human
2 Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

3 **SECTION 6. Medicaid Lock-In Program.**

4 The Division of Medical Assistance of the Department of Health and Human Services
5 (DMA) shall take the following steps to improve the effectiveness and efficiency of the
6 Medicaid lock-in program:

- 7 (1) Establish written procedures for the operation of the lock-in program,
8 including specifying the responsibilities of DMA and the program
9 contractor.
- 10 (2) Establish procedures for the sharing of bulk data with the Controlled
11 Substances Regulatory Branch.
- 12 (3) In consultation with the Physicians Advisory Group, extend lock-in duration
13 to two years and revise program eligibility criteria to align the program with
14 the statewide strategic goals for preventing prescription drug abuse. DMA
15 shall report an estimate of the cost-savings from the revisions to the
16 eligibility criteria to the Joint Legislative Program Evaluation Oversight
17 Committee and the Joint Legislative Oversight Committee on Health and
18 Human Services within one year of the lock-in program again becoming
19 operational.
- 20 (4) Develop a Web site and communication materials to inform lock-in
21 enrollees, prescribers, pharmacists, and emergency room health care
22 providers about the program.
- 23 (5) Increase program capacity to ensure that all individuals who meet program
24 criteria are locked in.
- 25 (6) Conduct an audit of the lock-in program within six months of the lock-in
26 program again becoming operational in order to evaluate the effectiveness of
27 program restrictions in preventing overutilization of controlled substances,
28 identify any program vulnerabilities, and address whether there is evidence
29 of any fraud or abuse within the program.

30 DMA shall report to the Joint Legislative Program Evaluation Oversight Committee by
31 September 30, 2014, on its progress towards implementing all items included in this section.

32 **SECTION 7. Statewide Strategic Plan.**

33 (a) There is hereby created the Prescription Drug Abuse Advisory Committee, to be
34 housed in and staffed by the Department of Health and Human Services (DHHS). The
35 Committee shall develop and, through its members, implement a statewide strategic plan to
36 combat the problem of prescription drug abuse. The Committee shall include representatives
37 from the following, as well as any other persons designated by the Secretary of Health and
38 Human Services:

- 39 (1) The Division of Medical Assistance, DHHS.
- 40 (2) The Division of Mental Health, Developmental Disabilities, and Substance
41 Abuse Services, DHHS.
- 42 (3) The Division of Public Health, DHHS.
- 43 (4) The Office of Rural Health and Community Care, DHHS.
- 44 (5) The State Bureau of Investigation.
- 45 (6) The Attorney General's Office.
- 46 (7) The following health care regulatory boards with oversight of prescribers
47 and dispensers of prescription drugs:
 - 48 a. North Carolina Board of Dental Examiners.
 - 49 b. North Carolina Board of Nursing.
 - 50 c. North Carolina Board of Podiatry Examiners.
 - 51 d. North Carolina Medical Board.

- e. North Carolina Board of Pharmacy.
- (8) The UNC Injury Prevention Research Center.
- (9) The substance abuse treatment community.
- (10) Community Care of North Carolina's (CCNC's) Project Lazarus.
- (11) Governor's Institute on Substance Abuse, Inc.
- (12) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

(b) In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:

- (1) Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.
- (2) Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).
- (3) Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).
- (4) Identify strategic issues based on SWOC and GAP analyses.
- (5) Formulate strategies and resources for addressing these issues.

(c) The strategic plan for reducing prescription drug abuse shall include three to five strategic goals that are outcome-oriented and measurable. Each goal must be connected with objectives supported by the following four mechanisms of the system:

- (1) Oversight and regulation of prescribers and dispensers by state health care regulatory boards.
- (2) Operation of the Controlled Substances Reporting System.
- (3) Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.
- (4) Enforcement of state laws for the misuse and diversion of controlled substances.
- (5) Any other appropriate mechanism identified by the Committee.

(d) DHHS, in consultation with the Prescription Drug Abuse Advisory Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress toward achieving goals and objectives and must recommend actions to be taken when performance falls short.

(e) Beginning on December 1, 2015, and annually thereafter, DHHS shall submit an annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 8. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Health Care Committee

Name of Committee

6/11/14
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE
CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Stevens	NCNA
Ada Shola	DHHS
Harry Lyle	MWC
Kaitlin Rotherick	" "
SHENEKA JONES	DELTA SIGMA THETA SORORITY, INC.
Deandra Nwusome	Delta Sigma Theta Sorority, Inc.
Deborah R Howard	Delta Sigma Theta Sorority, Inc.
Betty L. Reed	Delta Sigma Theta Sorority, Inc.
Sylvia Jones	Delta Sigma Theta Sorority, Inc.
Carolyn S. Snipes	Oxford-Henderson (DST)

VISITOR REGISTRATION SHEET

Health Care Committee

6-11-14

Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nilam Patel	DHHS / CSRS
Devon Scott	Governor's Institute / Raleigh
SCOTT PROZAK HUBBELL	DHHS / DPH
Annalisa Dixon	NL
Sandra Brown mrs	citizen
Will Bennett	NCMS
Jennifer Gasperini	MGMA
Ghali Hasan	Forsyth
Daniel Barbara	North Carolina Association of Pharmacists
Chuck Stone	SEARC ✓
Dana Sipes	SA

VISITOR REGISTRATION SHEET

Health Care Committee

Name of Committee

6/11/14

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jay Campbell	NC Board of Pharmacy
Don Heron	Wm
Bobby D. White	NC DENTAL BOARD
Joann Spivill	NCAPP
Amy Hobbs	CCNC
Ken Melton	K.M.A.
Jennifer Haisword	NCDOL
Charles King	UNC School of government
Hays Griggs	CCNC
Colleen Kochaneck	KL6
Elizabeth Robinson	NORMA
W. H. Poffe, Jr	NCDS & NCPTA

VISITOR REGISTRATION SHEET

Health Care Committee

Name of Committee

6-11-14

Date _____

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME**FIRM OR AGENCY AND ADDRESS**

Bill Scobbin

75

Don't know

DHS

John Deiborno

Brubaker & Assoc.

John McMillan

MF-5