2015-2016

SENATE
HEALTH CARE

MINUTES

Senate Committee on Health Care
Tuesday, March 10, 2015 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 10, 2015 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: Terry Barnhardt, Ed Kesler and Hal Roach. He then recognized the Pages: Kaitlin Avery of Winterville; Eryn Olmo of Holly Springs; Reaghan Waites and Rachel Bass, both of Raleigh.

Senator Pate recognized Senator Tillman to explain SB 7 "Allowing Seating for Food Stand Customers." A PCS was offered and accepted. After the bill had been explained, there was a lengthy question and answer session in which Larry Michaels, Section Chief with the Dept. of Public Health, explained the Department's concerns over the bill. After much discussion, Senator Jim Davis moved for a favorable report of the PCS, unfavorable to the original bill. Motion carried, and the bill was re-referred to the Commerce Committee.

Senate Bill 114 "Custodial Parent/Party Cooperate w/Child Support" was next on the agenda to be brought before the Committee. Senator Randleman explained the bill and Senator McKissick moved for a favorable report; motion carried. The bill was re-referred to the Judiciary I Committee.

The meeting adjourned at 11:50 a.m.

Louis M Pate Jr.
Senator Louis M. Pate, Jr.
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

SENATE COMMITTEE ON HEALTH CARE
TUESDAY, MARCH 10, 2015
11:00 A.M.
ROOM 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Introduction of Sergeants-at-Arms

BILLS:

BILL NO.	SHORT TITLE	SPONSOR
SB 7	ALLOW SEATING FOR FOOD STAND CUSTOMERS	SEN. TILLMAN
SB 114	CUSTODIAL PARENT/PARTY COOPERATE W/CHILD SUPP.	SEN. RANDLEMAN SEN. TARTE SEN. BINGHAM

ADJOURNMENT

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, March 10, 2015

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

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

SB 7 Allow Seating for Food Stand Customers.

Draft Number:	S7-PCS15094-SH-3
Sequential Referral:	Commerce
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Jerry Tillman will handle SB 7

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 7
PROPOSED COMMITTEE SUBSTITUTE S7-PCS15094-SH-3

Short Title: Allow Seating for Food Stand Customers. (Public)

Sponsors:

Referred to:

February 2, 2015

A BILL TO BE ENTITLED

AN ACT ALLOWING FOOD STANDS TO PROVIDE TABLES AND CHAIRS FOR CUSTOMERS TO USE WHILE CONSUMING DRINKS OR FOOD UPON THE PREMISES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding a new subsection to read:

"(a6) Notwithstanding any provision of this Part or any rules adopted pursuant to G.S. 130A-335(e), a food stand may elect to provide tables and chairs for customers to use while eating or drinking on the premises without obtaining a restaurant permit, unless the Department of Health and Human Services demonstrates that this type of seating arrangement poses a threat to public health and safety."

SECTION 2. This act becomes effective October 1, 2015.

SENATE BILL 7:
Allow Seating for Food Stand Customers

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Commerce	**Date:**	March 9, 2015
Introduced by:	Sen. Tillman	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition S7-CSSH-3		

SUMMARY: ***Senate Bill 7 allows a food stand to provide tables and chairs for customers eating or drinking on the premises without obtaining a restaurant permit, unless the seating arrangement poses a threat to public health and safety. The act would become effective October 1, 2015.***

The PCS deletes the second sentence in Section 1 of the original bill.

CURRENT LAW:

G.S. 130A-248 pertains to the regulation of food and lodging establishments. G.S. 130A-248(a) requires the Commission for Public Health to adopt rules governing the sanitation of establishments that prepare or serve drink or food for pay.

A food establishment must obtain a permit and no permit is issued until an evaluation by the regulatory authority shows that the establishment is in compliance. The regulatory authority is required to impose conditions if necessary to ensure the food establishment remains in compliance. (15A NCAC 18A .2659)

A "**food stand**" is defined as a food establishment that prepares or serves food and that does not provide seating facilities for customers to use while eating or drinking. (15A NCAC 18A.2651(6))

A "**restaurant**" is a food establishment that prepares or serves food and provides seating. (15A NCAC 18A.2651(18))

G.S. 130-335 pertains to wastewater collection, treatment and disposal. **G.S. 130-335(e)** requires the rules of the Commission and the rules of the local board of health to address specified items related to wastewater collection, treatment and disposal systems. The rules regarding required design capacity and required design volume for wastewater systems shall provide that exceptions may be granted upon showing that a system is adequate to meet actual daily water consumption. The design of a sewage treatment and disposal system is based on the type and use of the establishment. Flow rates for various establishments including restaurants and food stands are outlined in the rules (15A NCAC 18A.1949).

BILL ANALYSIS:

Senate Bill 7 amends G.S. 130A-248 to add a new subsection pertaining to food stands. Notwithstanding Chapter 130A, Article 8, Part 6, Regulation of Food and Lodging Facilities and G.S. 130-335(e), the new subsection would allow a food stand, without obtaining a restaurant permit, to provide tables and chairs for customers to use while eating or drinking on the premises unless the Department of Health and Human Services demonstrates that this type of seating arrangement poses a threat to public health and safety.

EFFECTIVE DATE: This bill would become effective October 1, 2015.

O. Walker Reagan
Director

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1

SENATE BILL 7

Short Title:	Allow Seating for Food Stand Customers.	(Public)
Sponsors:	Senators Tillman (Primary Sponsor); Brown and B. Jackson.	
Referred to:	Rules and Operations of the Senate.	

February 2, 2015

A BILL TO BE ENTITLED

AN ACT ALLOWING FOOD STANDS TO PROVIDE TABLES AND CHAIRS FOR CUSTOMERS TO USE WHILE CONSUMING DRINKS OR FOOD UPON THE PREMISES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding a new subsection to read:

"(a6) Notwithstanding any provision of this Part or any rules adopted pursuant to G.S. 130A-335(e), a food stand may elect to provide tables and chairs for customers to use while eating or drinking on the premises without obtaining a restaurant permit, unless the Department of Health and Human Services demonstrates that this type of seating arrangement poses a threat to public health and safety. For the purpose of this subsection, "food stand" means a food establishment that holds a valid permit to prepare or serve food without seating facilities for customers to use while eating or drinking."

SECTION 2. This act becomes effective October 1, 2015.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, March 10, 2015

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

FAVORABLE

SB **114** Custodial Parent/Party Cooperate w/Child Supp.

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

TOTAL REPORTED: 1

Senator Shirley Randleman will handle SB 114

SENATE BILL 114:
Custodial Parent/Party Cooperate w/Child Supp

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Judiciary I	**Date:**	March 9, 2015
Introduced by:	Sens. Randleman, Tarte, Bingham	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 114 requires the Division of Child Development and Early Education and the Division of Social Services to develop a plan to require a person with primary custody of a child receiving child care subsidy payments to cooperate with county child support services as a condition of receiving the subsidy payments. A report on the plan is required to be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.***

[As introduced, this bill was identical to H120, as introduced by Rep. R. Turner, which is currently in House Children, Youth, and Families, if favorable, Judiciary III.]

BACKGROUND:

The North Carolina Child Support Services Program is overseen by the NC Department of Health and Human Services, Division of Social Services (DSS), and primarily administered by the counties. Federally required by Title IV-D of the Social Security Act, services include location of the non-custodial parent, collection and distribution of child support payments, and establishment, review and modification of child support orders.

The Child Care Subsidy Program provides financial assistance to parents for their child care needs. The child care subsidy is based on an assessment of need, income and family size. Counties receive a combination of federal and state funding from the Department of Health and Human Services, Division of Child Development and Early Education (DCDEE) for subsidized child care services.

Senate Bill 114 is a recommendation by the Child Support Subcommittee of the Joint Legislative Program Evaluation Oversight Committee.

The Program Evaluation Division issued its final report to the Joint Legislative Program Evaluation Oversight Committee on July 16, 2014, entitled Revising State Child Support Incentive System Could Promote Improved Performance of County Programs. That report can be found at the following link:

http://www.ncleg.net/PED/Reports/2014/ChildSupport.html

BILL ANALYSIS:

Senate Bill 114 would require that DCDEE and DSS develop a plan to require a custodial parent, or other relative or person with primary custody of the child, who is receiving child care subsidy payments to cooperate with county child support services programs as a condition of receiving child care subsidy payments.

In developing the plan, the DCDEE and DSS are required to consider each of the following:

(1) The number of child care subsidy cases that would be referred to county child support services programs.
(2) Whether there are any disparities between child support services programs administered directly by the county DSSs versus programs administered by a vendor.
(3) The access and exchange of information between county child support services programs/systems and child care subsidy services/systems and any differences that may create a conflict in coordination.
(4) Any implementation issues related to IV-D child support cases versus non-IV-D child support cases.
(5) Any impact on the families involved and the need to incorporate good cause exceptions for cooperation with county child support services programs.
(6) Any costs to implement the plan.
(7) The development of any forms needed to implement the plan.
(8) Transition time needed to implement the plan and to coordinate any interface with current IT systems.
(9) Any training needs and costs associated with training.
(10) Other states that have implemented a similar plan.
(11) Other programs of public assistance in this State requiring coordination with child support services programs.
(12) The need to update any current policies or procedures related to child care subsidy payments and child support payments.
(13) Any other issues DCDEE or DSS deem relevant.

The report on this required plan and any recommendations would be due to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than February 1, 2016.

EFFECTIVE DATE: July 1, 2015

SENATE BILL 114*

Short Title:	Custodial Parent/Party Cooperate w/Child Supp.	(Public)
Sponsors:	Senators Randleman, Tarte, Bingham (Primary Sponsors); Clark, Krawiec, and Newton.	
Referred to:	Rules and Operations of the Senate.	

February 27, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION AND THE DIVISION OF SOCIAL SERVICES, TO DEVELOP A PLAN REQUIRING A CUSTODIAL PARENT OR OTHER RELATIVE OR PERSON WITH PRIMARY CUSTODY OF A CHILD RECEIVING CHILD CARE SUBSIDY PAYMENTS TO COOPERATE WITH COUNTY CHILD SUPPORT SERVICES PROGRAMS AS A CONDITION OF RECEIVING CHILD CARE SUBSIDY PAYMENTS, AS RECOMMENDED BY THE CHILD SUPPORT SUBCOMMITTEE OF THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) It is the intent of the General Assembly that the Department of Health and Human Services, Division of Child Development and Early Education (DCDEE) and the Division of Social Services (DSS), implement a process requiring child care subsidy recipients to participate in child support services programs. To that end, DCDEE and DSS shall develop a plan requiring a custodial parent or other relative or person with primary custody of the child who is receiving child care subsidy payments to cooperate with county child support services programs as a condition of receiving child care subsidy payments. In developing the plan, the DCDEE and DSS shall, at a minimum, consider each of the following:

(1) The number of child care subsidy cases that would be referred to county child support services programs.

(2) Whether there are any disparities between child support services programs administered directly by the county department of social services versus those programs administered by a vendor through a contract with the county department of social services, specifically as related to maintaining consistent communication.

(3) The access and exchange of information between county child support services programs/systems and child care subsidy services/systems and any differences that may create a conflict in coordinating child care subsidy payments with child support services.

(4) Any implementation issues related to IV-D child support cases versus non-IV-D child support cases.

(5) Any impact on the families involved and the need to incorporate good cause exceptions for cooperation with county child support services programs

similar to those for Temporary Assistance for Needy Families (TANF) and Medicaid.

(6) Any costs to implement the plan, including any automation costs associated with connecting the child care subsidy payments system to the child support payments system.

(7) The development of any forms needed to implement the plan.

(8) Transition time needed to implement the plan and to coordinate any interface with current systems, such as the North Carolina Automated Collection and Tracking System (NC ACTS) and North Carolina Families Accessing Services through Technology (NC FAST).

(9) Any training needs and costs associated with training.

(10) Other states that have implemented a similar plan as proposed in this section.

(11) Other programs of public assistance in this State requiring coordination with child support services programs.

(12) The need to update any current policies or procedures related to child care subsidy payments and child support payments.

(13) Any other issues DCDEE or DSS deem relevant.

SECTION 1.(b) The Division of Child Development and Early Education and the Division of Social Services shall submit a report on the plan, along with any recommendations, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than February 1, 2016.

SECTION 2. This act becomes effective July 1, 2015.

Committee Sergeants at Arms

NAME OF COMMITTEE Senate Comm. on Health Care

DATE: 3-10-15 **Room:** 544 LOB

House Sgt-At Arms:

1. **Name:** _____
2. **Name:** _____
3. **Name:** _____
4. **Name:** _____
5. **Name:** _____

Senate Sgt-At Arms:

1. **Name:** Terry Barnhardt
2. **Name:** Ed Kesler
3. **Name:** Hal Roach
4. **Name:** _____
5. **Name:** _____

SENATE PAGES ATTENDING

COMMITTEE: Health Care

DATE: 3-10, TIME: 11 AM, ROOM: 544

Pages: Please print legibly.....*or else!!!!!!!!!!!!!!!!*

Page Name	Hometown	Sponsoring Senator
1 Kaitlin Avery	Winterville	Donald Davis
2 Eryn Olmo	Holly Springs	Barringer ~~Barefoot~~
3 Reagan Wartes	Raleigh	Chad Barefoot
4 Rachel Bass	Raleigh	John Alexander
5		
6		
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
(Committee Name)

3-10-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Marge	NCRLA
[illegible]	DHHS
Trent Womble	DHHS
Penny Griffin	School of Gov.
Amy McConkey	NC Beverage
Andy Chase	KMA
TJ Bunbee	NP
Joanna Spruill	NCAFP
Susan Harrison	NCSSWA
[illegible] McConnell	Carolinas HealthCare System
Christine Craig	WakeMed
Marty Bocock	Prime Therapeutics
Jennifer Gasperini	NCMS
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	NCKNT
[illegible]	[illegible]

09-21-201

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
(Committee Name)

3-10-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	MP
Joyce Peters	CSS
LaTonia C Rayam	CSS
Sandra Chestnut	DHHS
Joel Mayo	GDM + Assoc
Shonda Flax	NOP
Jamal Cates	CFSA
Tonya Hoath	TSS
J Peters	CSS

09-21-201

Senate Committee on Health Care
Tuesday, March 31, 2015 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 31, 2015, in Room 544 of the Legislative Office Building. Seventeen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing the pages—Alex Epley of Onslow County, Elijah Ellison of Durham County, Nathan Oakley of Durham County, Janssen Slade of Durham County, and Drew West of Buncombe County, and the Sergeants-at-Arms—Hal Roach and Steve Wilson.

Senator Rabon was recognized and presented Senate Bill 215—Abolish Brunswick County Coroner. After questions and answers from Committee members, Senator Bingham moved for a favorable report. The motion passed.

Senator Curtis was recognized and presented Senate Bill 290—Allow Early Refills of Prescription Eye Drops. Senator Rabin moved for a favorable report. The motion passed.

Senator Hartsell moved for consideration of a PCS for Senate Bill 291; the motion passed. Senator Hartsell then presented and the PCS for Senate Bill 291—Extend Overnight Respite Pilot Program. Brent Lucas, of Program Evaluation Division answered a question of a Committee member regarding where the pilot program has been implemented. Senator McKissick moved for a favorable report to the PCS, unfavorable as to the original bill. The motion passed.

The meeting adjourned at 11:30 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
Tuesday	March 31, 2015	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 215	Abolish Brunswick County Coroner.	Senator Rabon
SB 290	Allow Early Refills of Prescription Eye Drops.	Senator Curtis
SB 291	Extend Overnight Respite Pilot Program.	Senator Hartsell

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

Senate Committee on Health Care
Tuesday, March 31, 2015, 11:00 AM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Introduction of Sergeants-at-Arms

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 215	Abolish Brunswick County Coroner.	Senator Rabon
SB 290	Allow Early Refills of Prescription Eye Drops.	Senator Curtis
SB 291	Extend Overnight Respite Pilot Program.	Senator Hartsell

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, March 31, 2015

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

FAVORABLE

SB **215** Abolish Brunswick County Coroner.

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

SB **290** Allow Early Refills of Prescription Eye Drops.

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

TOTAL REPORTED: 2

Senator William Rabon will handle SB 215
Senator David Curtis will handle SB 290

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Wednesday, April 01, 2015

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

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

SB **291** Extend Overnight Respite Pilot Program.

Draft Number:	S291-PCS45342-SH-11
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	Appropriations/Base Budget
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Report 2 of 2

Senator Fletcher Hartsell will handle SB 291

SENATE BILL 215:
Abolish Brunswick County Coroner

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Judiciary I	**Date:**	March 30, 2015
Introduced by:	Sen. Rabon	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: House Bill 215 provides that the Office of Coroner in Brunswick County shall be abolished at the end of the current term or upon a vacancy of that office, whichever occurs first.

CURRENT LAW: Chapter 152 of the General Statutes sets out the laws relating to coroners in North Carolina, including election and vacancies in office, oaths, bonds, powers and duties.

BILL ANALYSIS: House Bill 215 provides that the Office of Coroner in Brunswick County shall be abolished at the earlier of a vacancy in that office or end of the current term. The bill further provides that Chapter 152 of the General Statutes does not apply to Brunswick County.

EFFECTIVE DATE: This act becomes effective on the earlier of a vacancy in the office of the coroner in Brunswick County or the expiration of the current term of office in 2016.

BACKGROUND: The state-wide medical examiner system was put into place through Session Law 1965-639. Since the late 1960s, counties have abolished the Office of the Coroner. Most recently, Session Law 2010-48 abolished the Office of the Coroner in Rutherford County. There remains less than ten counties with an elected coroner.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1

SENATE BILL 215

Short Title:	Abolish Brunswick County Coroner.	(Local)
Sponsors:	Senator Rabon (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate.	

March 11, 2015

A BILL TO BE ENTITLED

AN ACT TO ABOLISH THE OFFICE OF CORONER IN BRUNSWICK COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. The office of coroner in Brunswick County is abolished.

SECTION 2. Chapter 152 of the General Statutes is not applicable to Brunswick County.

SECTION 3. This act is effective on the earlier of a vacancy in the office of coroner in Brunswick County or the expiration of the current term of office in 2016.

SENATE BILL 290:
Allow Early Refills of Prescription Eye Drops

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 27, 2015
Introduced by:	Sen. Curtis	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 290 amends the Pharmacy Practice Act to authorize pharmacists to dispense early refills of prescription eye drops.***

CURRENT LAW:

Article 4A of Chapter 90 regulates the practice of pharmacy. G.S. 90-85.32 directs the North Carolina Board of Pharmacy (Board) to adopt rules governing the filling, refilling and transfer of prescription orders that are not inconsistent with other provisions of the law regulating drugs and devices. The statute specifies that the rules must assure the safe and secure distribution of drugs and devices.

The Board adopted 21 NCAC 46.1802(a) that deal with the frequency of prescription refills. It reads as follows:

> (a) Authorization for prescription refills is presumed to be within the prescribed dosage or normal therapeutic use. Refilling prescriptions more frequently than the prescribed dosage would require, or refilling prescriptions in significant excess of normal therapeutic use, may be considered as negligence under G.S. 90-85.38(a)(9).

BILL ANALYSIS:

Senate Bill 290 would direct the Board of Pharmacy to adopt rules that allow for early eye drop prescription refills by pharmacists. The bill would direct the Board to adopt rules accounting for the two following scenarios:

- Filling or refilling a prescription at 70% of the predicted number of days of use **without** obtaining authorization from the prescriber.
- Filling or refilling a prescription earlier than 70% of the predicted number of days **with** an authorization from the prescriber for patients who have difficulty using the product.

BACKGROUND: According to the American Glaucoma Society[1] over 2/3 of patients have trouble administering a single drop of prescription eye medications. Dosages for prescription eye medications are generally based upon drops.

As an example of an instance of early eye drop refills, Medicare guidelines allowed for patients to obtain eye drop refills at 70% of the predicted use of days. Thus, people on Medicare are able to refill eye drop prescriptions on day 21 for a 30-day prescription.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

[1] www.amercicanglaucomasociety.net/patients/position_statements/glaucoma_eye_drop_availability

SENATE BILL 290

Short Title:	Allow Early Refills of Prescription Eye Drops.	(Public)
Sponsors:	Senators Curtis (Primary Sponsor); Brock, Rabin, Sanderson, and Waddell.	
Referred to:	Rules and Operations of the Senate.	

March 17, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE PHARMACY PRACTICE ACT TO AUTHORIZE PHARMACISTS TO DISPENSE EARLY REFILLS OF TOPICAL OPHTHALMIC PRODUCTS (EYE DROPS).

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.32(a) reads as rewritten:

"(a) Except as otherwise provided in this section, the Board may adopt rules governing the filling, refilling and transfer of prescription orders not inconsistent with other provisions of law regarding the distribution of drugs and devices. The rules shall ~~assure~~ do all of the following:

(1) Assure the safe and secure distribution of drugs and devices. ~~Prescriptions~~

(2) Prohibit prescriptions marked PRN ~~shall not be~~from being refilled more than one year after the date issued by the prescriber unless otherwise specified.

(3) In order to prevent unintended interruptions in drug therapy and if there are authorized refills remaining, permit both of the following with respect to dispensing topical ophthalmic products:

a. Filling or refilling a prescription at seventy percent (70%) of the predicted number of days of use without obtaining subsequent authorization or a new authorization from the prescriber.

b. For patients who have difficulty using the topical ophthalmic product and with authorization from the prescriber, filling or refilling a prescription earlier than seventy percent (70%) of the predicted number of days of use."

SECTION 2. This act becomes effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE DRS15108-MG-95 (03/12)

Short Title:	Extend Overnight Respite Pilot Program.	(Public)
Sponsors:	Senator Hartsell (Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT EXTENDING THE DURATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OVERNIGHT RESPITE PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Section 3 of S.L. 2011-104 reads as rewritten:

"**SECTION 3.** This act becomes effective when it becomes law; adult day care programs participating in the pilot shall be selected and have received an initial inspection by January 1, 2012; and this act is repealed ~~June 1, 2015.~~June 30, 2016."

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

SENATE BILL 291:
Extend Overnight Respite Pilot Program

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 30, 2015
Introduced by:	Sen. Hartsell	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition S291-CSSH-11		

SUMMARY: The PCS for Senate Bill 291 extends until June 30, 2017 the Adult Day Care Overnight Respite Pilot Program authorized by S.L. 2011-104 and provides a more comprehensive evaluation of the provision of overnight respite in an adult day care setting.

CURRENT LAW:

G.S. 131D-6(a) provides that, "It is the policy of this State to enable people who would otherwise need full-time care away from their own residences to remain in their residences as long as possible and to enjoy as much independence as possible. One of the programs that permits adults to remain in their residences with their families is adult day care."

G.S. 131D-6 (b) defines adult day care as the provision of group care and supervision in a place other than the usual place of abode on a less than 24-hour basis to adults who may be physically or mentally disabled. The Department of Health and Human Services annually inspects and certifies all adult day care programs in accordance with rules adopted by the Social Services Commission.

G.S. 143B-181.10(a) specifies that a respite care program provides needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems.

S.L. 2011-104 (SB 512) required the Department of Health and Human Services (DHHS) Secretary to select two to four stable and successful DHHS-certified adult day care programs in which to conduct a pilot program to provide overnight respite services. The enacted legislation specified criteria for the selection and administration of the pilot programs. The State was not authorized to pay for any overnight respite services offered through the pilot program and the pilot is not eligible to enroll or participate in the Medicaid program. The adult day care programs were selected and the pilot took place. The Program Evaluation Division (PED) conducted an evaluation of the pilot and provided a report: Overnight Respite Pilot at Adult Day Care Facilities Perceived as Favorable, but Lacked Objective Measures of Success (October 2014). This act is scheduled to be repealed June 1, 2015.

BILL ANALYSIS:

The PCS for Senate Bill 291 extends the repeal date of the pilot program from June 1, 2015 to June 30, 2017. The PCS also requires the Department of Health and Human Services to work with the Program Evaluation Division to collect and provide additional information on the provision of overnight respite in an adult day care setting. The intent of the additional information is to assist in determining whether overnight respite in an adult day care setting is a worthwhile service.

The Program Evaluation Division is required to provide an interim report on the criteria specified in the PCS on or before December 1, 2015, and a final report on or before October 1, 2016, to the Joint

Legislative Program Evaluation Oversight Committee and to the Joint Legislative Oversight Committee on Health and Human Services.

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

BACKGROUND:
According to the Division of Aging and Adult Services, between years 2013-2033, the 65-74 year old population segment will increase 54%; the 75-84 year old population segment will increase 102%; and the 85+ year old population segment will increase 88%. By 2025, 90 North Carolina counties will have more people 60+ than children 0-17.

Adult Day Care entities are certified by the Division of Aging and Adult Services. There is a health model and a social model that serve older and disabled adults. According to information in the PED report, as of May 2014, there were 100 adult day care programs with 4,827 client slots. An adult day care provides a respite option for caregivers during the day, many times these caregivers go to work. At the end of the day, the adults leave the adult day care and return home. Among other activities, overnight respite provides relief to caregivers allowing them to attend to their own needs or to participate in out-of town activities.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 291
PROPOSED COMMITTEE SUBSTITUTE S291-CSSH-11 [v.4]

3/30/2015 6:19:40 PM

Short Title: Extend Overnight Respite Pilot Program. (Public)

Sponsors:

Referred to:

March 17, 2015

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE DURATION OF THE OVERNIGHT RESPITE PILOT PROGRAM AND TO PROVIDE A MORE COMPREHENSIVE EVALUATION OF THE PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Section 2 of S.L. 2011-104 reads as rewritten:

"**SECTION 2.(a)** The Department of Health and Human Services shall report on the status of the pilot once a year to the Program Evaluation Division. The Program Evaluation Division shall evaluate the provision of overnight respite services in an adult day care program through the experiences of this pilot. The evaluation shall include whether this pilot was successful as measured by the participants in receipt of overnight respite, the primary caregivers of participants, the adult day care programs participating in the pilot, and the Department of Health and Human Services. On or before October 1, 2014, the Program Evaluation Division shall provide a report to the General Assembly on the feasibility of continuing to provide overnight respite in an adult day care program.

SECTION 2.(b) Following the 2014 report and in order to provide a more comprehensive evaluation of the pilot, the Department of Health and Human Services shall coordinate with the Program Evaluation Division regarding the collection of additional information. The Program Evaluation Division shall specify what information the Department needs to collect and the timeframe for reporting the information. Based on information collected through the Department, the Program Evaluation Division shall provide information on each of the items below which will assist in determining whether the provision of overnight respite in an adult day care setting is a worthwhile service.

(1) The actual number of overnight respite participants per month.

(2) The percentage of an adult day care entity's clients that need overnight respite; the percentage of clients that use overnight respite; the percentage of clients using the service more than once if they had a need arise; the percentage of clients using overnight respite that are not regular adult day care clients; and the average monthly bed utilization for overnight respite at each location.

(3) Customer satisfaction levels for individuals who participate and their families.

(4) Satisfaction levels of adult day care entities offering overnight respite services.

(5) The viability of an adult day care offering overnight respite from a cost/benefit standpoint.

(6) The need for overnight respite options in the State currently and the need forecast through 2025.

(7) The degree to which overnight respite provided in an adult day care setting supports older and disabled adults who wish to live in the least restrictive and supportive setting possible.

(8) The potential for saving public dollars due to delayed institutionalization when overnight respite is readily available.

(9) Based on the pilot, a recommendation regarding whether the State should allow the provision of overnight respite in an adult day care setting beyond the pilot.

(10) A recommendation regarding whether the current regulations are sufficient to ensure the safety and well-being of residents participating in overnight respite in an adult day care setting.

(11) A recommendation regarding whether adult day care overnight respite should require certification or licensure.

(12) If a recommendation is made to expand overnight respite in an adult day care setting, the feasibility of funding sources other than private pay, including the possibility of coverage for the service under Medicaid.

The Program Evaluation Division shall provide an interim report on the criteria specified in this Section on or before December 1, 2015, and a final report on or before October 1, 2016, to the Joint Legislative Program Evaluation Oversight Committee and to the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 2. Section 3 of S.L. 2011-104 reads as rewritten:

"**SECTION 3.** This act becomes effective when it becomes law; adult day care programs participating in the pilot shall be selected and have received an initial inspection by January 1, 2012; and this act is repealed ~~June 1, 2015.~~June 30, 2017."

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

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 31, 2015

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Bucks Gunnells	NC Bev
Adam Talowitz	[illegible]
Jesse Goodman	DHHS/DHSR
Glenda Artis	DHHS/DAAS
Megan Lamphere	DHHS/DHSR
Andy Chase	KMA
[signature]	SEANC
Tonya Horton	TSS
Amanda Horacker	TSS
Ryan Blackledge	ConnHealth
Allison Cooper	NCOA
Trent Womble	DHHS
Adam Sholar	DHHS
Brian Menwald	WM
Lori Ann Harris	GHHA
[illegible]	[illegible]
[signature]	MWC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 31, 2015

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Dawn B Clark	UNC Dept Govt
Mike Lanza	ACP
	NCBOP
Erica Nelson	NCHA
Lanier Hudgson	UNC Health Care
Marty Bocock	Prime Therapeutics
Kay Castillo	NASWNC
Gerald Hammond	CHOR
Lexi Morgan	NCRMA
Tammy Stevens	Stevens Lobby
Wendy Kelly	Focus Carolina
	CSS
Adrianne Drollette	NCSOS
Bill Rabon	ACP
Colleen Kachmark	KCG
Ken Lewis	NCAHP
PETERS	CSS

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09-21-201

Senate Committee on Health Care
Tuesday, April 14, 2015 at 11:00 am
544 Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 11:00 am on April 14, 2015, in room 544 of the Legislative Office Building. Sixteen members were present.

Senator Tommy Tucker, Chair, presided.

Senator Tucker opened by the meeting by welcoming everyone and recognizing the Senate Sergeant-at-Arms – Donna Blake and Steve Wilson. Senator Tucker also recognized the Senate Pages - Charlie Crumpler of Harnett County (sponsored by Senator Rabin) and Sarah Strickland of Sampson County (sponsored by Senator Berger).

Senator Tucker recognized Senator Hise for a motion to consider a proposed committee substitute for SB 423. The motion passed unanimously by voice vote. Senator Barringer presented the bill. Senator Barringer introduced Drs. David Marlett and Jamie Parson of Appalachian State University to speak on behalf of the bill. Senator Barringer recognized three foster children who had aged out of the system to speak on behalf of the bill. Senator Curtis moved for an unfavorable report as to the bill, but favorable as to the committee substitute with a sequential referral to the Insurance and Judiciary I Committees. The motion passed favorably by voice vote.

Senator Tucker recognized Senator Pate to present SB 487. Senator Pate presented the bill. Senator Rabin moved for a favorable report as to the bill. Senator Bingham raised questions concerning the bill which Adam Sholar with the North Carolina Department of Health and Human Services addressed. Senator Rabin's motion for a favorable report as to the bill passed unanimously by voice vote.

Senator Tucker recognized Senator Barringer to present SB 366. Senator Barringer presented the bill. Senator Wade moved for a favorable report as to the bill. The motion passed favorably by voice vote.

The meeting adjourned at 11:34 pm.

Tommy Tucker
Senator Tommy Tucker
Presiding

Joey Stansbury
Committee Clerk

Senate Committee on Health Care
Tuesday, April 14, 2015, 11:00 AM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 423	Foster Care Family Act.	Senator Barringer Senator Harrington Senator Tucker
SB 487	Health Choice Technical Revisions.-AB	Senator Pate
SB 366	Amend Certain Reqs/Permanency Innovation Comm.	Senator Barringer

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, April 14, 2015

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

FAVORABLE

SB **366** Amend Certain Reqs/Permanency Innovation Comm.

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

SB **487** Health Choice Technical Revisions.-AB

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

TOTAL REPORTED: 2

Senator Tamara Barringer will handle SB 366
Senator Louis Pate will handle SB 487

SENATE BILL 423:
Foster Care Family Act

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Judiciary I	**Date:**	April 13, 2015
Introduced by:	Sens. Barringer, Harrington, Tucker	**Prepared by:**	Tawanda Foster Committee Counsel
Analysis of:	PCS to First Edition S423-CSTV-4		

SUMMARY:

Senate Bill 423 would amend the law applying to foster care families and the children in their care through: 1) implementation of a reasonable and prudent parent standard; 2) providing liability insurance for foster parents; 3) reducing barriers to obtaining a drivers license for foster children; and 4) requiring the Department of Health and Human Services (DHHS) to study a Medicaid waiver for children with serious emotional disturbance.

[As introduced, this bill was identical to H407, as introduced by Reps. Stevens, Glazier, which is currently in House Judiciary III.]

BILL ANALYSIS:

Section 2.1 creates a new section to establish the reasonable and prudent parenting standard.

Section 2.2 amends G.S. 7B-505(b) to require DHHS to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of nonsecure custody hearings..

Section 2.3 amends G.S. 7B-800.1(a)(4) to require the court to consider whether parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement and support prior to the adjudicatory hearing.

Section 2.4 amends G.S. 7B-901 to require the court to inquire about efforts made to identify and notify parents with custody of a sibling of the as potential resources for placement and support at the disposition hearing.

Section 2.5 amends the law to allow a county department of social services (DSS) with custody of a juvenile to make decisions about matters generally made by a juvenile's custodian, and to provide or withhold permission to allow a juvenile to participate in normal childhood activities. This section also adds requirements for every permanency planning hearing for a juvenile in the custody of DSS who is age 14 years or more that, the court inquire and make written findings regarding the child's transition to adulthood and whether another planned permanent living arrangement would be an appropriate permanent plan for the juvenile.

Section 3.1 amends the insurance law to require the Rate Bureau to develop an optional policy form or endorsement that provides liability insurance to licensed foster parents.

Section 4.1 amends the law to deem minors 16 years or older in the custody of the DSS competent to contract for the purchase of an automobile insurance policy.

Section 4.2 amends G.S. 20-11(i) to allow an application for a permit or license to be signed by both the applicant and specified other person when the applicant is in the legal custody of the DSS.

Section 4.3 amends the law to provide that the owner of a motor vehicle who is a foster parent does not violate the Financial Responsibility Act by allowing their foster child to operate their motor vehicle when the foster child is covered by a nonowner motor vehicle insurance policy.

Section 5.1(a) requires the DHHS, Division of Medical Assistance to design and draft, but not submit, a 1915 (c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings.

Section 5.1(b) requires the DHHS to report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015.

EFFECTIVE DATE: Parts 2 and 4 of this act would become effective on October 1, 2015. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 423
PROPOSED COMMITTEE SUBSTITUTE S423-CSTV-4 [v.9]

4/13/2015 9:34:09 PM

Short Title: Foster Care Family Act. (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENT STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING TO THE JUVENILE CODE UNDER THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENTS DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act".

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the Department of Health and Human Services must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives, including parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian, including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parent standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information,

drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-43. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the Department of Health and Human Services, Division of Social Services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.2. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;
(2) A person approved by the applicant's parent or guardian; or
(3) A person approved by the Division.
(4) With respect to minors in the legal custody of the Department of Health and Human Services, Division of Social Services, any of the following:
a. A guardian ad litem or attorney advocate appointed to advocate for the minor.
b. A case manager or other type of case worker assigned to work with the minor.
c. If no person listed in sub-subdivisions a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.3. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) The owner of a motor vehicle who is a foster parent providing foster care to a person between the ages of 16 and 21 shall not violate the requirements of this Article by allowing the motor vehicle to be operated by the person if the person is covered by a nonowner motor vehicle insurance policy issued by the North Carolina Reinsurance Facility as authorized by G.S. 58-37-35(g)(13). Nothing in this section is intended to prevent a foster parent from including a foster child on the parent's own motor vehicle insurance policy."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act becomes effective October 1, 2015. The remainder of this act is effective when it becomes law.

SENATE BILL 423

Short Title:	Foster Care Family Act.	(Public)
Sponsors:	Senators Barringer, Harrington, Tucker (Primary Sponsors); Bingham, Brock, Bryant, Clark, Cook, Daniel, J. Davis, Ford, Foushee, Hartsell, Hise, J. Jackson, Krawiec, Lowe, McInnis, Pate, Rabin, Rabon, Robinson, Sanderson, Smith, Smith-Ingram, Soucek, Tarte, Van Duyn, Waddell, and Woodard.	
Referred to:	Rules and Operations of the Senate.	

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENT STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING TO THE JUVENILE CODE UNDER THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY DIRECTING THE NORTH CAROLINA REINSURANCE FACILITY TO MAKE AVAILABLE A NONOWNER AUTOMOBILE INSURANCE POLICY FOR FOSTER CHILDREN, BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENTS DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act".

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent or the designated official at a child care institution where the child is placed, must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver or a county department of social services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) Neither the caregiver nor the county department of social services with custody of or placement authority over the child may be held liable for injuries to the child that occur as a result of authorization provided in this section, unless the action or inaction of the caregiver or county department of social services resulting in injury to the child is by willful or reckless misconduct."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning

the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives, including parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian, including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parent standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information, drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) The plan of Another Planned Permanent Living Arrangement (APPLA) is only available as a juvenile's primary permanent plan when the court concludes each of the following:

(1) The juvenile is 16 or 17 years old.
(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.
(3) There are compelling reasons why it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.
(4) APPLA is the best permanency plan for the juvenile.

(d) When APPLA is the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-43. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for all of the following:

(1) Acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.
(2) Acts or omissions of a child who is placed in a licensed family foster home or therapeutic foster home while the child is in the foster parent's care.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission of a foster parent of a child in a family foster home or therapeutic foster home when the act or omission is not in compliance with any written instructions received from the child placing agency or the Department of Health and Human Services regarding specific care and supervision of the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1 G.S. 58-37-35(g) reads as rewritten:

"(g) Except as may be delegated specifically to others in the plan of operation or reserved to the members, power and responsibility for the establishment and operation of the Facility is vested in the Board of Governors, which power and responsibility include but is not limited to the following:

...

(13) To establish, with the approval of the Commissioner, a form of nonfleet private passenger motor vehicle liability insurance providing named nonowner coverage for a foster child in State custody. This policy shall meet the following requirements:
a. It shall be available to any foster child who does not own a motor vehicle. For purposes of this subdivision, "foster child" shall mean a person placed into foster care, as that term is defined by G.S. 131D-10.2, who is (i) a child between the ages of 16 and 18 or (ii) between the ages of 18 and 21.
b. The policy shall apply only to the foster child.

c. The policy shall provide the minimum coverages specified under this Chapter and Chapter 20 of the General Statutes in order to provide the proof of financial responsibility required by G.S. 20-7(c1).

d. The policy shall cover the operation by the foster child of any automobile furnished or available to the foster child for regular use.

e. The policy shall be portable if the foster child's placement for foster care changes, as long as the placement is located in this State.

f. The rates charged by the Facility shall be the same as those provided for a clean risk under subsection (l) of this section, for as long as the foster child meets the criteria for classification as a clean risk under that subsection. If the foster child no longer meets that criteria, the Facility may charge the actuarially sound and self-supporting rate."

SECTION 4.2. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the Department of Health and Human Services, Division of Social Services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.3. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;

(2) A person approved by the applicant's parent or guardian; or

(3) A person approved by the Division.

(4) With respect to minors in the legal custody of the Department of Health and Human Services, Division of Social Services, any of the following:

a. A guardian ad litem or attorney advocate appointed to advocate for the minor.

b. A case manager or other type of case worker assigned to work with the minor.

c. If no person listed in sub-subdivisions a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.4. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) The owner of a motor vehicle who is a foster parent providing foster care to a person between the ages of 16 and 21 shall not violate the requirements of this Article by allowing the motor vehicle to be operated by the person if the person is covered by a nonowner motor vehicle insurance policy issued by the North Carolina Reinsurance Facility as authorized by G.S. 58-37-35(g)(13). Nothing in this section is intended to prevent a foster parent from including a foster child on the parent's own motor vehicle insurance policy."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve

children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Part 4 of this act becomes effective October 1, 2015. The remainder of this act is effective when it becomes law.

SENATE BILL 487:
Health Choice Technical Revisions.-AB

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	April 14, 2015
Introduced by:	Sen. Pate	**Prepared by:**	Kristen Harris
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 487 would make changes to Chapter 108A of the General Statutes as recommended by the Department of Health and Human Services.***

BILL ANALYSIS:

Section 1 would delete the obsolete definition of "predecessor plan" from Part 8 (Health Insurance Program for Children) of Chapter 108A (Social Services.)

Section 2 would add language to G.S. 108A-70.20 to require that claims made under the Health Insurance Program for Children be processed in accordance with the federal guidelines on the timely processing of claims.

Section 3 would repeal G.S. 108A-70.20A which established the Child Health Insurance Fund.

Section 4 would add language to G.S. 108A-70.21 stating that payments to Health Insurance Program for Children providers under Part 8 of Chapter 108A must be paid in full and not subject to cost settlement.

Section 5 would make conforming changes.

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

O. Walker Reagan
Director

S487-SMTU-11 E1 -V3

Research Division
(919) 733-2578

SENATE BILL 487

Short Title:	Health Choice Technical Revisions.-AB	(Public)
Sponsors:	Senators Pate (Primary Sponsor); and Hise.	
Referred to:	Rules and Operations of the Senate.	

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO UPDATE OUTDATED AND OBSOLETE PROVISIONS IN CHAPTER 108A OF THE GENERAL STATUTES ON THE NC HEALTH CHOICE PROGRAM IN ORDER TO AVOID CONFUSION BY STAKEHOLDERS AND TO INCREASE EFFICIENCIES IN THE ADMINISTRATION OF THE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-70.18 reads as rewritten:

"**§ 108A-70.18. Definitions.**

As used in this Part, unless the context clearly requires otherwise, the term:

(1) "Comprehensive health coverage" means creditable health coverage as defined under Title XXI.

(2) "Family income" has the same meaning as used in determining eligibility for the Medical Assistance Program.

( ) "FPL" or "federal poverty level" means the federal poverty guidelines established by the United States Department of Health and Human Services, as revised each April 1.

(- "Medical Assistance Program" means the State Medical Assistance Program established under Part 6 of Article 2 of Chapter 108A of the General Statutes.

~~(4a) "Predecessor Plan" means the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan in effect prior to July 1, 2008.~~

(5) "Program" means The Health Insurance Program for Children established in this Part.

(6) "State Plan" means the State Child Health Plan for the State Children's Health Insurance Program established under Title XXI.

(7) "Title XXI" means Title XXI of the Social Security Act, as added by Pub. L. 105-33, 111 Stat. 552, codified in scattered sections of 42 U.S.C.

(8) "Uninsured" means the applicant for Program benefits is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment."

SECTION 2. G.S. 108A-70.20 reads as rewritten:

"**§ 108A-70.20. Program established.**

The Health Insurance Program for Children is established. The Program shall be known as North Carolina Health Choice for Children, and it shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI and

related federal rules and regulations. Administration of ~~Program benefits and~~ claims processing shall be as ~~provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.~~described in 42 C.F.R. 447.45(d)(1).

SECTION 3. G.S. 108A-70.20A is repealed.

SECTION 4. G.S. 108A-70.21 reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

(b1) Payments. – Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, amounts allowable for prescription drugs under Medicaid. For all other providers, services provided to children enrolled in the Program shall be provided at rates equivalent to one hundred percent (100%) of Medicaid rates, less any co-payments assessed to enrollees under this Part. Payments to NC Health Choice Program providers under this Part shall be paid in full and shall not be subject to cost settlement."

SECTION 5. G.S. 108A-70.27 reads as rewritten:

"**§ 108A-70.27. Data collection; reporting.**

(a) The Department shall ensure that the following data are collected, analyzed, and reported in a manner that will most effectively and expeditiously enable the State to evaluate Program goals, objectives, operations, and health outcomes for children:

(1) Number of applicants for coverage under the Program;
(2) Number of Program applicants deemed eligible for Medicaid;
(3) Number of applicants deemed eligible for the Program, by income level, age, and family size;
(4) Number of applicants deemed ineligible for the Program and the basis for ineligibility;
(5) Number of applications made at county departments of social services, public health departments, and by mail;
(6) Total number of children enrolled in the Program to date and for the immediately preceding fiscal year;
(7) Total number of children enrolled in Medicaid through the Program application process;
(8) Trends showing the Program's impact on hospital utilization, immunization rates, and other indicators of quality of care, and cost-effectiveness and efficiency;
(9) Trends relating to the health status of children;
(10) Other data that would be useful in carrying out the purposes of this Part.

(b) Repealed by Session Laws 2013-360, s. 12A.8(e), effective July 1, 2013.

(c) The Division of Medical Assistance shall provide to the Department data required under this section that are collected by ~~the Plan~~ this Division. Data shall be reported by ~~the Plan~~ the Division of Medical Assistance in sufficient detail to meet federal reporting requirements under Title XXI. ~~The Plan shall report periodically to the Joint Legislative Oversight Committee on Health and Human Services claims processing data for the Program and any other information the Plan or the Committee deems appropriate and relevant to assist the Committee in its review of the Program.~~"

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

SENATE BILL 366:
Amend Certain Reqs/Permanency Innovation Comm

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	April 14, 2015
Introduced by:	Sen. Barringer	**Prepared by:**	Kristen Harris Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 366 would amend the reporting and meeting requirements of the Permanency Innovation Initiative Oversight Committee.***

BILL ANALYSIS:

Reporting Requirements

Under the proposed changes, instead of reporting to the General Assembly by September 15th of each year, the Committee would report to the chairs of the Senate and House Appropriations Committees on Health and Human Services and the Fiscal Research Division by February 15th of each year.

Meeting Requirements

Under the proposed changes, instead of meeting at least once a quarter, the Committee must meet at least twice a year.

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

O. Walker Reagan
Director

S366-SMTU-14 E1 -V1

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1

SENATE BILL 366

Short Title:	Amend Certain Reqs/Permanency Innovation Comm.	(Public)
Sponsors:	Senator Barringer (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate.	

March 24, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND THE REPORTING AND MEETING REQUIREMENTS UNDER THE LAWS PERTAINING TO THE PERMANENCY INNOVATION INITIATIVE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-10.9A reads as rewritten:

"**§ 131D-10.9A. Permanency Innovation Initiative Oversight Committee created.**

...

(d) Reports. – The Committee shall report its analysis and any findings and recommendations to the ~~General Assembly by September 15~~chairs of the Senate Appropriations Committee on Health and Human Services, the chairs of the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division by February 15 of each year.

(e) Organization. – The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Committee. The Committee shall meet at least ~~once a quarter~~twice each year upon the joint call of the cochairs. A quorum of the Committee is seven members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

...."

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

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

APRIL 14, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Peyton Maynard	GPA
Joel Maynard	
Daniel VanLiere	Valant Health
[illegible]	UNCG
Michelle Brooks	East Carolina University
Curtis McDonald	BMS
Joanna Spruill	NCAFP
Kenya Caldwell	NCAFP - MS4 (Med student)
Mariana Sheridan	NCAFP - MS4 (Med student)
Peters	CSS
Erica Nelson	NCHA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

APRIL 14, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Gasperini	NCMS
Rob Lamm	PCA
Vernon Walters, Jr	Methodist Children's Home
Harold Fernhandt	" "
Darryl Jackson	" "
Thom Goolsby	Goolsby Government Relations
Sarah Pfau	DMA, DHHS
Tina Gordon	NC Nurses Assoc
Jan Tillman, FNP-BC	NC Nurses Assoc. / ECU
Virginia McLean CPNP	NCNA
Amanda Honaker	TSS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

APRIL 14, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Susan McCracken	Appalach... State
Bob Mack	NCDOI
Ben Popkin	NCDOI
Mildred Spearman	NCAOC
Deana Fleming	NCAOC
Cindy Bizzell	NCAOC - GAL
Hugh Johnson	NCHCC
Lori Kroll	Novant Health
Thom Mc...	FWW...
Allison Stewart	cardinal Innovations
Debbi Fox-Davis	children's Home Society

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

APRIL 14, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Tamikca Stykes	Methodist Home For Children 1041 Washington St. Raleigh
Robby Hall	NC Association of County Directors of Social Services
Mike Strickland	Council for N.C. Rate Bureau
RAY EVANS	NORTH CAROLINA RATE BUREAU
Susan Valauri	Nationwide Ins.
Treva Johnson	Omni Visions Inc
Evelyn Lawrence	ETHOR
Judy Jenkins	Otsuka
Angenette Stephenson	NC DOS on behalf of NC DSS
Kevin Kelley	NC DHHS DSS
Demetrius Delvecchio	Senator Robinson

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

APRIL 14, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Bruce Stanley	Methodist Home for Children
Melissa Arkin	Strategic Behavioral Health
Regina Jarvis	Easter Seals UCP
[illegible]	[illegible]
Kay Castillo	NASW-NC
Tom Vilay Cuong	NC CHILD
John Hamrick	MFJS
Erin Fleck	senate staff
Annaliese Dolph	AD
David Kirkland	N.C. Board of Nursing
Elizabeth Wilin	NC Board of Nursing

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **Name of Committee**

APRIL 14, 2015 — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Danielle McConaga	NCDHHS / NCDSS
LAUREN ZINGRAFF	SAYSO, INC.
Gabrielle Foushee	Sayso, INC
Mandy Ableidinger	Benchmarks NC
Alex Hudson	Youth in Transition. Forsyth Co
Jenny Rahilly Cooper	Benchmarks NC
Debra Bronson	University of Mount Olive - Nurse of Day
Gail Lane MSN, RN, BC	NCNA. Nurse of the Day Roanoke Rapids, NC
Al Lane EMT	Roanoke Rapids, NC
Andy Chase	KMA
Shelita Lee	methodist Home for Children 1041 Washington St. Raleigh, NC 27605

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — APRIL 14, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Susan Fox	Duke Energy

Senate Pages

Charlie Crumpler of Harnett County sponsored by Senator Rabin

Sarah Strickland of Sampson County sponsored by Senator Berger

Senate Sergeant-at-Arms

Steve Wilson

Donna Blake

Senate Committee on Health Care
Tuesday, April 21, 2015 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 21, 2015 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: Steve McKaig and Dale Huff. He then introduced the Pages: Emily Braren of Sanford and Langden Ramseur of Gastonia.

Senator Pate asked Senator Brown to explain SB 368 "Recognize Department of Defense Child Care Standards." A PCS was offered and accepted. Senator Trudy Wade moved for a favorable report of the PCS with unfavorable to the original bill. Motion carried.

Senator Barringer was asked to explain SB 578, "Transition Certain Abuse Investigations/DCDEE". A PCS was offered and accepted. Senator Robinson moved for a favorable report as to the PCS, unfavorable as to original bill and referred to Judiciary II.

Senate Bill 367 "Achieving a Better Life Experience Act" was next for consideration. Senator Barringer was asked to explain the bill. Afterward, Senator Robinson moved for a favorable report of the PCS, unfavorable to the original bill with a referral to Finance. Motion carried.

Senator Bingham was called on to explain SB 286 "Regulate the Sale of E-Liquid Containers." Senator Woodard moved for a favorable report of the PCS, unfavorable to the original bill. Motion carried. The bill will go to the floor with an incarceration note.

Senate Bill 371 was heard next. Senator Rabin moved to consider the PCS. Senator Hartsell explained the bill. Senator Randleman made a motion for a favorable report of the PCS, unfavorable to original bill. Motion carried.

Senator Hartsell was called on again to explain Senate Bill 235, "Establish State Public Health Authority." Senator Hise moved to accept the PCS, motion carried. After the explanation of the bill, questions were asked and answered. Senator McKissick moved for a favorable report with unfavorable to the original bill. Motion carried.

The meeting adjourned at 11:45 am.

Louis M Pate Jr.
Senator Pate, Presiding

Edna Pearce
Edna Pearce, Clerk

SENATE COMMITTEE ON HEALTH CARE
TUESDAY, April 21, 2015
11:00 A.M.
ROOM 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Introduction of Sergeants-at-Arms

BILLS:

BILL NO.	SHORT TITLE	SPONSOR
SB 235	Establish State Public Health Authority	Senator Hartsell
SB 286	Regulate the Sale of E-Liquid Containers	Senator Bingham Senator D. Davis
SB 367	Achieving A Better Life Experience Act	Senator Barringer Senator Hise Senator Apodaca
SB 368	Recognize Dept. of Defense Child Care Standards	Senator Brown
SB 578	Transition Certain Abuse Investigations/ DCDEE	Senator Barringer Senator Hise Senator Tucker
~~SB 609~~ Pulled	Mandate Use/Controlled Substance Reporting System	Senator J. Davis
~~SB 705~~ Pulled	Ensure Fair Sale of Dorothea Dix Property	Senator Pate Senator Tucker Senator Hise
SB 371	LME/MCO Claims Reporting	Senator Hartsell

ADJOURNMENT

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Monday, April 20, 2015 12:18 PM
To: Sen. Fletcher Hartsell, Jr.; Sen. Stan Bingham; Sen. Don Davis; Sen. Tom Apodaca; Sen. Ralph Hise; Sen. Tamara Barringer; Sen. Harry Brown; Sen. Tommy Tucker; Sen. Jim Davis; Sen. Louis Pate
Cc: Gerry Johnson (Sen. Fletcher Hartsell); Judy Chriscoe (Sen. Stan Bingham); Maria Kinnaird (Sen. Stan Bingham); Blinda Edwards (Sen. Don Davis); Laura Kilian (Sen. Tom Apodaca); Julie Bradburn (Sen. Tom Apodaca); Susan Fanning (Sen. Ralph Hise); Gloria Whitehead (Sen. Tamara Barringer); Elizabeth Paul (Sen. Tamara Barringer); Elise McDowell (Sen. Harry Brown); Kristi Huff (Sen. Harry Brown); Joseph Stansbury (Sen. Tommy Tucker); Kaye Culberson (Sen. Jim Davis); Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Tuesday, April 21, 2015 at 11:00 AM - CORRECTED #1
Attachments: Add Meeting to Calendar_LINC_.ics

Principal Clerk ____
Reading Clerk ____

Corrected #1: SB 371 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
Tuesday	April 21, 2015	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 235	Establish State Public Health Authority.	Senator Hartsell
SB 286	Regulate the Sale of E-Liquid Containers.	Senator Bingham Senator D. Davis
SB 367	Achieving A Better Life Experience Act.	Senator Barringer Senator Hise Senator Apodaca
SB 368	Recognize Dept of Defense ChildCare Standards.	Senator Brown
SB 578	Transition Certain Abuse	Senator Barringer

	Investigations/DCDEE.	Senator Hise Senator Tucker
SB 609	Mandate Use/Controlled Sub. Reporting System.	Senator J. Davis
SB 705	Ensure Fair Sale of Dorothea Dix Property.	Senator Pate Senator Tucker Senator Hise
SB 371	LME/MCO Claims Reporting.	Senator Hartsell

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

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, April 21, 2015

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

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

SB **235** Establish State Public Health Authority.

Draft Number:	S235-PCS35265-SH-24
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	Yes

SB **286** Regulate the Sale of E-Liquid Containers.

Draft Number:	S286-PCS35262-TK-22
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

SB **367** Achieving A Better Life Experience Act.

Draft Number:	S367-PCS25236-SH-28
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Senator Fletcher Hartsell will handle SB 235
Senator Stan Bingham will handle SB 286
Senator Tamara Barringer will handle SB 367

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 235
PROPOSED COMMITTEE SUBSTITUTE S235-PCS35265-SH-24

Short Title: Establish Advisory Council on Rare Diseases. (Public)

Sponsors:

Referred to:

March 11, 2015

A BILL TO BE ENTITLED

AN ACT ESTABLISHING AN ADVISORY COUNCIL ON RARE DISEASES WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

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

"Part 5. Advisory Council on Rare Diseases.

"**§ 130A-33.52. Advisory Council on Rare Diseases; membership.**

(a) There is established the Advisory Council on Rare Diseases within the Department to advise the Secretary on research, diagnosis, treatment, and education relating to rare diseases. For purposes of this section, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb, as amended from time to time.

(b) The advisory council shall consist of the following members, who shall be appointed by the Secretary:

(1) Up to five physicians licensed and practicing in the State with experience researching, diagnosing, or treating rare diseases.

(2) A medical researcher with experience conducting research concerning rare diseases.

(3) A registered nurse or advanced practice registered nurse licensed and practicing in the State with experience treating rare diseases.

(4) One hospital administrator from each hospital in the State that provides care to persons diagnosed with a rare disease, or a designee of the hospital administrator.

(5) Two rare disease survivors over the age of 18.

(6) A caregiver of a pediatric rare disease survivor.

(7) A representative of the North Carolina Board of Education.

(8) A representative in the field of biostatistics.

(9) A representative in the field of public health.

(10) Up to three representatives of patient-based organizations operating within the State.

(c) The chairpersons of the Joint Legislative Oversight Committee on Health and Human Services, or the chairpersons' designees, shall be members of the advisory council.

(d) The Secretary, or the Secretary's designee, shall be an ex officio, nonvoting member of the advisory council and shall attend all meetings of the advisory council.

(e) Any member of the advisory council appointed under subsection (c) of this section may be a member of the General Assembly.

(f) All appointments to the advisory council shall be made not later than 30 days after the effective date of this section. Members appointed pursuant to subsection (b) of this section shall serve for a term of three years, and no member shall serve more than two consecutive terms.

(g) Members of the advisory council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, or travel and subsistence expenses in accordance with the provisions of G.S. 120-3.1, as applicable.

(h) All administrative support and other services required by the advisory council shall be provided by the Department.

(i) The Secretary shall schedule the first meeting of the advisory council, which shall be held not later than October 1, 2015. The members shall elect the chairperson of the advisory council from among the members of the council. A majority of the council members shall constitute a quorum. A majority vote of a quorum shall be required for any official action of the advisory council. The advisory council shall meet upon the call of the chairperson or upon the request of a majority of council members.

"**§ 130A-33.53. Advisory Council on Rare Diseases; powers and duties.**

The advisory council shall exercise the following powers and duties:

(1) Coordinate statewide efforts for the study of the incidence of rare disease within the State and the status of the rare disease community.

(2) Act as the advisory body on rare diseases to the Secretary on research, diagnosis, treatment, and education relating to rare diseases.

(3) Coordinate the performance of the advisory council's duties with other rare disease advisory bodies, community-based organizations, and other public and private organizations within the State for the purpose of ensuring greater cooperation regarding the research, diagnosis, and treatment of rare diseases between the State and federal agencies, including but not exclusive to, the United States National Institutes of Health (NIH) and the United States Food and Drug Administration (FDA). Such coordination shall require, when appropriate, the following:

a. Disseminating the advisory council's research, identified best practices, and policy recommendations.

b. Utilizing common research collection and dissemination procedures.

(4) Research and identify priorities relating to the quality and cost-effectiveness of, and access to, treatment and services provided to persons with rare diseases in the State; and develop policy recommendations on those issues.

(5) Identify best practices for rare disease care from other states and at the national level that will improve rare disease care in this State.

(6) Develop recommendations for effective strategies to raise public awareness of rare diseases in the State.

(7) Determine recommendations for best practices for ensuring that the public and health care providers are sufficiently informed of the most effective strategies for recognizing and treating rare diseases.

(8) Develop recommendations for effective strategies to aid in determining any genetic or environmental contributors to rare diseases.

(9) Not later than January 1, 2016, and annually thereafter, the advisory council shall report to the Joint Legislative Oversight Committee on Health and Human Services on the activities of the advisory council and its findings and recommendations regarding rare disease research and care in North Carolina.

(10) Apply for, and accept, any grant of money from the federal government, private foundations, or other sources which may be available for the

operation of the advisory council and State programs related to rare diseases."

SECTION 2. This act becomes effective July 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 286
PROPOSED COMMITTEE SUBSTITUTE S286-PCS35262-TK-22

Short Title: Regulate the Sale of E-Liquid Containers. (Public)

Sponsors:

Referred to:

March 16, 2015

A BILL TO BE ENTITLED

AN ACT PROHIBITING THE SALE OF E-LIQUID CONTAINERS WITHOUT CHILD-RESISTANT PACKAGING.

The General Assembly of North Carolina enacts:

SECTION 1. Article 52 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-401.18A. Sale of certain e-liquid containers prohibited.**

(a) The following definitions apply in this section:

(1) Child-resistant packaging. – Packaging that is designed or constructed to be significantly difficult for children under five years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for adults to use properly, but does not mean packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

(2) E-liquid. – A liquid product, whether or not it contains nicotine, that is intended to be vaporized and inhaled using a vapor product.

(3) E-liquid container. – A bottle or other container of e-liquid. The term does not include a container holding liquid that is intended for use in a vapor product if the container is pre-filled and sealed by the manufacturer and is not intended to be opened by the consumer.

(4) Vapor product. – Any noncombustible product that employs a mechanical heating element, battery, or electronic circuit regardless of shape or size and that can be used to heat a liquid solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe.

(b) It shall be unlawful for any person, firm, or corporation to sell, offer for sale, or introduce into commerce in this State an e-liquid container unless the container constitutes child-resistant packaging. Any person who violates this section is guilty of a Class A1 misdemeanor.

(c) Any person, firm, or corporation that violates the provisions of this section shall be liable in damages to any person injured as a result of the violation."

SECTION 2. This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

SENATE BILL 286:
Regulate the Sale of E-Liquid Containers

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	April 21, 2015
Introduced by:	Sens. Bingham, D. Davis	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition S286-CSTK-22		

SUMMARY: ***The PCS to S286 prohibits the sale of e-liquid containers without child-resistant packaging and creates a new Class A1 misdemeanor for a violation of the provisions prohibiting the sale of e-liquid containers without child-resistant packaging. Any person, firm, or corporation would also be liable for damages as a result of selling e-liquid containers without child-resistant packaging.***

BILL ANALYSIS:

The PCS to S286 prohibits the sale, offer of sale, or introduction into commerce, of e-liquid containers without child-resistant packaging. Child-resistant packaging is defined in the bill as:

> Packaging that is designed or constructed to be significantly difficult for children under five years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for adults to use properly, but does not mean packing which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

The term e-liquid filled container does not include a container holding liquid that is intended for use in a vapor product if the container is pre-filled and sealed by the manufacturer and is not intended to be opened by the consumer.

Senate bill 286 creates a new Class A1 misdemeanor for a violation of the provisions prohibiting the sale of e-liquid containers without child-resistant packaging. Any person, firm, or corporation in violation would also be liable in damages as a result of selling e-liquid containers without child-resistant packaging.

EFFECTIVE DATE: This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

O. Walker Reagan
Director

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Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1

SENATE BILL 286

Short Title:	Regulate the Sale of E-Liquid Containers.	(Public)
Sponsors:	Senators Bingham, D. Davis (Primary Sponsors); Bryant and Waddell.	
Referred to:	Rules and Operations of the Senate.	

March 16, 2015

A BILL TO BE ENTITLED

AN ACT PROHIBITING THE SALE OF E-LIQUID CONTAINERS WITHOUT CHILD-RESISTANT PACKAGING AND SAFETY WARNING LABELS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 52 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-401.18A. Sale of certain e-liquid containers prohibited.**

(a) The following definitions apply in this section:

(1) Child-resistant packaging. – Packaging that is designed or constructed to be significantly difficult for children under five years of age to open or obtain a toxic or harmful amount of the substance contained therein within a reasonable time and not difficult for normal adults to use properly, but does not mean packing which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

(2) E-liquid. – A liquid product, whether or not it contains nicotine, that is intended to be vaporized and inhaled using a vapor product.

(3) E-liquid container. – A bottle or other container of e-liquid. The term does not include a container holding e-liquid in a cartridge that is intended for use in a vapor product if the cartridge is prefilled and sealed by the manufacturer and is not intended to be opened by the consumer.

(4) Vapor product. – Any noncombustible product that employs a mechanical heating element, battery, or electronic circuit regardless of shape or size and that can be used to heat a liquid solution contained in a vapor cartridge. The term includes an electronic cigarette, electronic cigar, electronic cigarillo, and electronic pipe.

(b) It shall be unlawful for any person, firm, or corporation to sell, offer for sale, or introduce into commerce in this State an e-liquid container unless the container meets all of the following requirements:

(1) Constitutes child-resistant packaging.

(2) Is labeled with safety warnings consistent with rules adopted by the North Carolina Commission for Public Health.

(c) Any person, firm, or corporation that violates the provisions of this section shall be liable in damages to any person injured as a result of the violation and also shall be guilty of a Class A1 misdemeanor."

SECTION 2. G.S. 130A-29(c) is amended by adding a new subdivision to read:

"(12) Establishing standards for safety warnings to be included on labels for e-liquid containers as defined in G.S. 14-401.18A."

SECTION 3. This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 367
PROPOSED COMMITTEE SUBSTITUTE S367-CSSH-28 [v.3]

4/20/2015 3:21:18 PM

Short Title: ABLE Act for NC. (Public)

Sponsors:

Referred to:

March 24, 2015

A BILL TO BE ENTITLED

AN ACT TO ENACT THE ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Article 6 of Chapter 147 of the General Statutes is amended by adding a new section to read:

"**§147-86.5. Achieving a Better Life Experience Trust Fund.**

(a) Policy. – The General Assembly of North Carolina hereby finds and declares that encouraging and assisting individuals and families in saving private funds for the purpose of supporting individuals with disabilities to maintain health, independence, and a better quality of life is fully consistent with and furthers the long-established policy of the State to provide tools that strengthen opportunities for personal economic development and long-term financial planning.

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

(1) ABLE account. – An account established and owned by an eligible individual and maintained pursuant to this section.

(2) Account owner. – The person who enters into an ABLE savings agreement pursuant to the provisions of this section. The account owner must be the designated beneficiary. A trustee or guardian may be appointed a signatory of an ABLE account to act on behalf of an account owner or a designated beneficiary who is a minor or lacks capacity to enter into an agreement.

(3) Contracting state. – A state without a qualified ABLE program that has entered into a contract with North Carolina to provide residents of the contracting state access to a qualified ABLE program.

(4) Designated beneficiary. – The eligible individual who established and owns an ABLE account.

(5) Disability certification. – With respect to an individual, documentation that satisfies each of the following conditions:

a. A certification to the satisfaction of the Secretary of the Treasury of the United States by the individual or the parent or guardian of the individual that the individual has a medically determinable physical or mental impairment that (i) results in marked and severe functional limitations and can be expected to result in death or (ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

b. The individual is blind or disabled within the meaning of section 1614(a)(2) of the Social Security Act, and the blindness or disability

occurred before the individual attained 26 years of age. A copy of the individual's diagnosis, signed by a physician, relating to the individual's relevant impairment or impairments meeting the criteria of section 1861(r)(1) of the Social Security Act.

(6) Eligible individual. – An individual who, for a taxable year, either (i) is entitled to benefits based on blindness or disability under Title II or XVI of the Social Security Act, 42 U.S.C. § 301 et seq., and the blindness or disability is a preexisting condition that occurred before the date on which the individual attained 26 years of age or (ii) has a disability certification filed with the Secretary of the Treasury of the United States for the taxable year.

(7) Member of the family. – A brother, sister, stepbrother, or stepsister.

(8) Qualified disability expense. – An expense related to an eligible individual's blindness or disability that is incurred for the benefit of the eligible individual who is the designated beneficiary.

(c) Achieving a Better Life Experience (ABLE) Trust Fund. – There is established an ABLE trust fund to be administered by the State Treasurer to enable contributors to save funds to meet the costs of the qualified disability expenses of eligible individuals.

(d) Accounts. – The following provisions apply to an ABLE Account:

(1) An account owner or contributor may establish an account by making an initial contribution to the ABLE Trust Fund, signing an application form approved by the State Treasurer, and naming the designated beneficiary. If the contributor is not the account owner, the account owner shall also sign the application form.

(2) Any person may make contributions to an account after the account is opened.

(3) Contributions to an account shall be made only in cash.

(4) Contributions to an account shall not exceed (i) maximum contribution limits applicable to program accounts in accordance with the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295 and (ii) the amount reasonably necessary to meet the designated beneficiary's qualified disability expenses.

(5) An account owner may change the designated beneficiary of an account to an eligible individual who is a member of the family of the former designated beneficiary. At the direction of an account owner, all or a portion of an account may be transferred to another account of which the designated beneficiary is a member of the family of the designated beneficiary of the transferee account if the transferee account was created pursuant to this section or in accordance with the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295.

(e) Contributions. – The State Treasurer is authorized to accept, hold, invest, and disburse contributions, and interest earned on such contributions, from contributors as trustee of the ABLE Trust Fund. The State Treasurer shall hold all contributions to the ABLE Trust Fund, and any earnings thereon, in a separate trust fund and shall invest the contributions in accordance with this section. The assets of the ABLE Trust Fund shall at all times be preserved, invested, and expended solely for the purposes of the trust fund and shall be held in trust for the contributors and their designated beneficiaries. Nothing in this Article shall be construed to prohibit the State Treasurer from accepting, holding, and investing contributions from contributors who reside outside of North Carolina. Neither the contributions to the ABLE Trust Fund, nor the earnings thereon, shall be considered State moneys, assets of the State, or State

revenue for any purpose. An account or a legal or beneficial interest in an account is not subject to attachment, levy, or execution by a creditor of designated beneficiary.

(f) Investments. – The State Treasurer shall determine an appropriate investment strategy for the ABLE Trust Fund. The strategy may include a combination of fixed income assets and preferred or common stocks issued by any company incorporated, or otherwise located within or without the United States, or other appropriate investment instruments to achieve long-term return through a combination of capital appreciation and current income. Unless prohibited by federal law, contributions to the ABLE Trust Fund may be invested in the individual, common, or collective trust funds of an investment manager provided that the investment manager meets both of the following conditions:

(1) The investment manager has assets under management of at least one hundred million dollars ($100,000,000) at all times.

(2) The investment manager is subject to the jurisdiction and regulation of the United States Securities and Exchange Commission.

(g) Administration. – The State Treasurer shall develop and perform all functions necessary and desirable to (i) administer the ABLE Trust Fund in such a manner as to meet and comply with the requirements of the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295 and federal regulations under the act and (ii) provide such other services as the State Treasurer shall deem necessary to facilitate participation in the ABLE Trust Fund. The State Treasurer is further authorized to obtain the services of such investment advisors or program managers as may be necessary for the proper administration and marketing and investment strategy for the ABLE Trust Fund.

(h) Limitations. – The State Treasurer, in administering the ABLE Trust Fund, shall ensure each of the following:

(1) A rollover from an ABLE account does not apply to an amount paid or distributed from the ABLE account to the extent that, not later than the 60th day after the date of the payment or distribution, the amount received is paid into another ABLE account for the benefit of the same designated beneficiary or an eligible individual who is a member of the family of the designated beneficiary. The limitation of this subdivision does not apply to a transfer if the transfer occurs within 12 months after the date of a previous transfer under this subchapter for the benefit of the designated beneficiary.

(2) A person may make contributions for a taxable year for the benefit of an individual who is an eligible individual for the taxable year to an ABLE account that is established to meet the qualified disability expenses of the designated beneficiary of the account.

(3) A designated beneficiary is limited to one ABLE account.

(4) An ABLE account may be established only for a designated beneficiary who is a resident of North Carolina or a resident of a contracting state.

(5) Except as permitted under the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, a person does not direct the investment of any contributions to or earnings from the Achieving a Better Life Experience Program more than two times each year.

(6) An account or a legal or beneficial interest in an account is not assignable, pledged, or otherwise used to secure or obtain a loan or other advancement.

(7) Separate records and accounting are maintained for each ABLE account.

(8) Reports are made no less frequently than annually to each ABLE account owner.

(9) A trustee or guardian appointed as a signatory of an ABLE account does not have or acquire any beneficial interest in the account and administers the account for the benefit of the designated beneficiary.

(i) Disclaimer. – Nothing in this section shall be construed to create any obligation of the State Treasurer, the State, or any agency or instrumentality of the State to guarantee for the benefit of any parent, other interested party, or designated beneficiary the rate of return or other return for any contribution to the ABLE Trust Fund and the payment of interest or other return on any contribution to the ABLE Trust Fund.

(j) Fees. – The State Treasurer may establish application, account, and administration fees in an amount not to exceed the amount necessary to offset the costs of the program.

(k) Means-Tested Programs. – Notwithstanding any other provision of law, assets of and distributions for qualified disability expenses from an ABLE account shall be disregarded for purposes of determining whether a designated beneficiary's financial circumstances meet the eligibility requirements of other State assistance programs.

(l) Claim for Medical Assistance Benefits. – To the extent provided in subsection 529A(f) of the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, upon the death of a designated beneficiary, the State shall have a claim for payment from the beneficiary's account in an amount equal to the total medical assistance paid for the designated beneficiary after the establishment of the account. The State may file its claim for repayment from the account with the State Treasurer within 60 days of receiving notice from the State Treasurer of the death of the designated beneficiary.

(m) Notice of the Death of a Designated Beneficiary. – Within 15 days of the date the State Treasurer receives notice of the death of a designated beneficiary, the State Treasurer shall provide notice of the designated beneficiary's death to the Division of Medical Assistance, Department of Health and Human Services.

(n) Notice to Account Owner for Designated Beneficiary Receiving Medicaid. – Notice of the State's right to file a claim against the estate following the death of a designated beneficiary who received Medical assistance must be provided to the account owner. The notice shall be on a form prescribed by the Division of Medical Assistance, Department of Health and Human Services, and shall explain:

(1) The types of Medicaid payments subject to a claim against the estate.

(2) That a claim will not be made if the individual is survived by a legal spouse, a child or children under the age of 21, or a blind or disabled child or children of any age who became blind or disabled before age 21 and still live on the property of the deceased designated beneficiary.

(3) That a claim against the estate is limited to specified conditions.

(4) That a claim against the estate may be waived in the case of undue hardship and the procedure for claiming an undue hardship."

SECTION 2. The Department of Health and Human Services shall provide information and assistance to the Department of State Treasurer in establishing and implementing this act. The Department of State Treasurer shall consult with other departments as needed.

SECTION 3. The Department of State Treasurer and the Department of Health and Human Services are authorized to adopt rules necessary to implement this act.

SECTION 4. This act is effective when it becomes law. The State Treasurer shall begin accepting contributions authorized under this act when federal regulations regarding the Achieving a Better Life Experience Program, as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, have been issued and provide the guidance necessary to implement the Achieving a Better Life Experience Trust Fund Program established in this act.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Wednesday, April 22, 2015

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

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

SB **368** Recognize Dept of Defense ChildCare Standards.

Draft Number:	S368-PCS15229-SH-26
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

SB **578** Transition Certain Abuse Investigations/DCDEE.

Draft Number:	S578-PCS15231-TV-8
Sequential Referral:	Judiciary II
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Harry Brown will handle SB 368
Senator Tamara Barringer will handle SB 578

CMR209-V-1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 368
PROPOSED COMMITTEE SUBSTITUTE S368-PCS15229-SH-26

Short Title: DOD-Certified Child Care & State Subsidy. (Public)

Sponsors:

Referred to:

March 24, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING UNITED STATES DEPARTMENT OF DEFENSE-CERTIFIED CHILD CARE FACILITIES TO PARTICIPATE IN THE STATE-SUBSIDIZED CHILD CARE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-106.2. Department of Defense-certified child care facilities.**

(a) As used in this section, the phrase "Department of Defense-certified child care facility" shall include child development centers, family child care homes, and school-aged child care facilities operated aboard a military installation under the authorization of the United States Department of Defense (Department of Defense) certified by the Department of Defense.

(b) Procedure Regarding Department of Defense-Certified Child Care Facilities. –

(1) Department of Defense-certified child care facilities shall file with the Department a notice of intent to operate a child care facility in a form determined by the Department of Defense.

(2) As part of its notice, each Department of Defense-certified child care facility shall file a report to the Department indicating that it meets the minimum standards for child care facilities as provided by the Department of Defense.

(3) Department of Defense-certified child care facilities that meet all the requirements of this section shall be exempt from all other requirements of this Article and shall not be subject to licensure.

(4) For purposes of the North Carolina Subsidized Child Care Program, Department of Defense-certified child care facilities shall be reimbursed as follows:

a. Department of Defense-certified child care facilities that are accredited by the National Association for the Education of Young Children (NAEYC) shall be reimbursed at the five-star-rated license rate.

b. All other Department of Defense-certified child care facilities shall be reimbursed at the four-star-rated license rate."

SECTION 2. G.S. 143B-168.15(g) reads as rewritten:

"(g) Not less than thirty percent (30%) of the funds spent in each year of each local partnership's direct services allocation shall be used to expand child care subsidies. To the extent practicable, these funds shall be used to enhance the affordability, availability, and quality of child care services as described in this section. The North Carolina Partnership may

increase this percentage requirement up to a maximum of fifty percent (50%) when, based upon a significant local waiting list for subsidized child care, the North Carolina Partnership determines a higher percentage is justified. Local partnerships shall spend an amount for child care subsidies that provides at least fifty-two million dollars ($52,000,000) for the Temporary Assistance to Needy Families (TANF) maintenance of effort requirement and the Child Care Development Fund and Block Grant match requirement. Funds allocated under this section shall supplement and not supplant any federal or State funds allocated to Department of Defense-certified child care facilities licensed under G.S. 110-106.2."

SECTION 3. Department of Defense-certified child care facilities licensed pursuant to G.S. 110-106.2, as enacted in Section 1 of this act, may participate in the State-subsidized child care program that provides for the purchase of care in child care facilities for minor children in needy families; provided, that funds allocated from the State-subsidized child care program to Department of Defense-certified child care facilities shall supplement and not supplant funds allocated in accordance with G.S. 143B-168.15(g). Payment rates and fees for military families who choose Department of Defense-certified child care facilities and who are eligible to receive subsidized child care shall be as determined by the General Assembly in the Current Operations Appropriations Act for the 2015-2016 fiscal year.

SECTION 4. This act becomes effective January 1, 2016.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Wednesday, April 22, 2015

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

SB **368** Recognize Dept of Defense ChildCare Standards.

Draft Number:	S368-PCS15229-SH-26
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

SB **578** Transition Certain Abuse Investigations/DCDEE.

Draft Number:	S578-PCS15231-TV-8
Sequential Referral:	Judiciary II
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Harry Brown will handle SB 368
Senator Tamara Barringer will handle SB 578

CMR209-V-1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 578
PROPOSED COMMITTEE SUBSTITUTE S578-PCS15231-TV-8

Short Title: Transition Certain Abuse Investigations/DCDEE. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO TRANSITION ABUSE AND NEGLECT INVESTIGATIONS IN CHILD CARE FACILITIES TO THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-101(3) reads as rewritten:

"**§ 7B-101. Definitions.**

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

...

(3) Caretaker. – Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent, foster parent, an adult member of the juvenile's household, an adult relative entrusted with the juvenile's care, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services. ~~"Caretaker" also means any person who has the responsibility for the care of a juvenile in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes and includes any person who has the approval of the care provider to assume responsibility for the juveniles under the care of the care provider.~~ Nothing in this subdivision shall be construed to impose a legal duty of support under Chapter 50 or Chapter 110 of the General Statutes. The duty imposed upon a caretaker as defined in this subdivision shall be for the purpose of this Subchapter only."

SECTION 2. G.S. 7B-300 reads as rewritten:

"**§ 7B-300. Protective services.**

The director of the department of social services in each county of the State shall establish protective services for juveniles alleged to be abused, neglected, or dependent.

Protective services shall include the screening of reports, the performance of an assessment using either a family assessment response or an investigative assessment response, casework, or other counseling services to parents, guardians, or other caretakers as provided by the director to help the parents, guardians, or other caretakers and the court to prevent abuse or neglect, to

improve the quality of child care, to be more adequate parents, guardians, or caretakers, and to preserve and stabilize family life.

~~The provisions of this Article shall also apply to child care facilities as defined in G.S. 110-86.~~"

SECTION 3. G.S. 7B-301 reads as rewritten:

"**§ 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.**

(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the department's assessment of the alleged abuse, neglect, dependency, or death as a result of maltreatment.

~~Upon receipt of any report of sexual abuse of the juvenile in a child care facility, the director shall notify the State Bureau of Investigation within 24 hours or on the next workday. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the assessment there is reason to suspect that sexual abuse has occurred, the director shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report.~~

(b) Any person or institution who knowingly or wantonly fails to report the case of a juvenile as required by subsection (a) of this section, or who knowingly or wantonly prevents another person from making a report as required by subsection (a) of this section, is guilty of a Class 1 misdemeanor.

~~(c) A director of social services who receives a report of sexual abuse of a juvenile in a child care facility and who knowingly fails to notify the State Bureau of Investigation of the report pursuant to subsection (a) of this section is guilty of a Class 1 misdemeanor.~~"

SECTION 4. G.S. 7B-302(a) reads as rewritten:

"(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough assessment, using either a family assessment response or an investigative assessment response, in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the assessment. When the report alleges neglect or dependency, the director shall initiate the assessment within 72 hours following receipt of the report. When the report alleges abandonment, the director shall immediately initiate an assessment, take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The assessment and evaluation shall include a visit to the place where the juvenile ~~resides, except when the report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes. When a report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes, a visit to the place where the juvenile resides is not required.~~ resides. When the report alleges abandonment, the assessment shall include a request from the

director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child."

SECTION 5. G.S. 7B-307 reads as rewritten:

"**§ 7B-307. Duty of director to report evidence of abuse, neglect; investigation by local law enforcement; notification of Department of Health and Human ~~Services and State Bureau of Investigation.~~Services.**

(a) If the director finds evidence that a juvenile may have been abused as defined by G.S. 7B-101, the director shall make an immediate oral and subsequent written report of the findings to the district attorney or the district attorney's designee and the appropriate local law enforcement agency within 48 hours after receipt of the report. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate and coordinate a criminal investigation with the protective services assessment being conducted by the county department of social services. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate and may request the director or the director's designee to appear before a magistrate.

If the director receives information that a juvenile may have been physically harmed in violation of any criminal statute by any person other than the juvenile's parent, guardian, custodian, or caretaker, the director shall make an immediate oral and subsequent written report of that information to the district attorney or the district attorney's designee and to the appropriate local law enforcement agency within 48 hours after receipt of the information. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate a criminal investigation. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate.

If the report received pursuant to G.S. 7B-301 involves abuse or neglect of a juvenile or child maltreatment, as defined in G.S. 110-105.3, in child care, the director shall notify the Department of Health and Human Services within 24 hours or on the next working day of receipt of the report.

~~(b) If the director finds evidence that a juvenile has been abused or neglected as defined by G.S. 7B-101 in a child care facility, the director shall immediately so notify the Department of Health and Human Services and, in the case of sexual abuse, the State Bureau of Investigation, in such a way as does not violate the law guaranteeing the confidentiality of the records of the department of social services.~~

~~(c) Upon completion of the assessment, the director shall give the Department written notification of the results of the assessment required by G.S. 7B-302. Upon completion of an assessment of sexual abuse in a child care facility, the director shall also make written notification of the results of the assessment to the State Bureau of Investigation.~~

The director of the department of social services shall submit a report of alleged abuse, neglect, or dependency cases or child fatalities that are the result of alleged maltreatment to the central registry under the policies adopted by the Social Services Commission."

SECTION 6. G.S. 110-105 reads as rewritten:

"**§ 110-105. Authority to inspect facilities.**

(a) The Department shall have authority to inspect facilities without notice when it determines there is cause to believe that an emergency situation exists or there is a complaint alleging a violation of licensure law. When the Department is notified by the county director of social services that the director has received a report of child maltreatment in a child care facility, or when the Department is notified by any other person that alleged child maltreatment has occurred in a facility, the Commission's rules shall provide for an inspection conducted without notice to the child care facility to determine whether the alleged child maltreatment has occurred. The inspection shall be conducted within seven calendar days of receipt of the report. Additional visits shall be conducted, as warranted.

(a1) The Commission shall adopt standards and rules under this subsection which provide for the following types of inspections:

(1) An initial licensing inspection, which shall not occur until the administrator of the facility receives prior notice of the initial inspection visit;

(2) A plan for visits to all facilities, including announced and unannounced visits, which shall be confidential unless a court orders its disclosure;

(3) An inspection that may be conducted without notice, if there is ~~probable~~ cause to believe that an emergency situation exists or there is a complaint alleging a violation of licensure law. ~~When the Department is notified by the county director of social services that the director has received a report of child abuse or neglect in a child care facility, or when the Department is notified by any other person that alleged abuse or neglect has occurred in a facility, the Commission's rules shall provide for an inspection conducted without notice to the child care facility to determine whether the alleged abuse or neglect has occurred. This inspection shall be conducted within seven calendar days of receipt of the report, and when circumstances warrant, additional visits shall be conducted.~~

The ~~Secretary or the Secretary's designee,~~Department, upon presenting appropriate credentials to the operator of the child care facility, may perform inspections in accordance with the standards and rules promulgated under this subsection. The ~~Secretary or the Secretary's designee~~Department may inspect any area of a building in which there is reasonable evidence that children are in ~~care.~~care or in which the Department has cause to believe that conditions in that area of a building pose a potential risk to the health, safety, or well-being of children in care.

(b) If an operator refuses to allow the Secretary or the Secretary's designee to inspect the child care facility, the Secretary shall seek an administrative warrant in accordance with G.S. 15-27.2."

SECTION 7. G.S. 110-105.2 is repealed.

SECTION 8. Article 7 of Chapter 110 of the General Statutes is amended by adding the following new sections to read:

"**§ 110-105.3. Child maltreatment.**

(a) The purpose of this section is to assign the authority to investigate instances of child maltreatment in child care facilities to the Department of Health and Human Services, Division of Child Development and Early Education. The General Assembly recognizes that the ability to properly investigate child maltreatment in licensed child care facilities is dependent upon the cooperation of State and local law enforcement agencies, as well as county departments of social services.

(b) The following definitions shall apply in this Article:

(1) Caregiver. – The operator of a licensed child care facility or religious-sponsored child care facility, a child care provider, as defined in G.S. 110-90.2(a)(2), a volunteer, or any person who has the approval of the provider to assume responsibility for children under the care of the provider.

(2) Child care facilities. – Any of the following:

a. All facilities required to be licensed under this Article.

b. All religious-sponsored facilities operating pursuant to G.S. 110-106.

c. All locations where children are being cared for by someone other than their parent or legal guardian that require a license under this Article but have not been issued a license by the Department.

(3) Child maltreatment. – Any act or series of acts of commission or omission by a caregiver that results in harm, potential for harm, or threat of harm to a child. Acts of commission include, but are not limited to, physical, sexual,

and psychological abuse. Acts of omission include, but are not limited to, failure to provide for the physical, emotional, or medical well-being of a child, and failure to properly supervise children, which results in exposure to potentially harmful environments.

(c) The Department, local departments of social services, and local law enforcement personnel shall cooperate with the medical community to ensure that reports of child maltreatment in child care facilities are properly investigated.

(d) When a report of child maltreatment is received, the Department shall make a prompt and thorough assessment to ascertain the facts of the case, the extent of the maltreatment, and the risk of harm to children enrolled at the child care facility. When the report alleges maltreatment meeting the definition of abuse or neglect as defined in G.S. 14-318.2 and G.S. 14-318.4, the Department shall contact local law enforcement officials to investigate the report.

(e) During the pendency of an investigation, the Department may issue a protection plan restricting an individual alleged to have maltreated a child from being on the premises of the facility while children are in care. The Department may also suspend activities at a facility under investigation, including, but not limited to, transportation, aquatic activities, and field trips.

(f) At any time during the pendency of a child maltreatment investigation, the Department may order immediate corrective action as required to protect the health, safety, or welfare of children in care. If the corrective action does not occur within the period specified in the corrective action order, the Department may take administrative action to protect the health, safety, or welfare of the children at the child care facility.

(g) The Department may, in accordance with G.S. 150B-3(c), summarily suspend the license of a child care facility if the Department determines that emergency action is required to protect the health, safety, or welfare of the children in a child care facility regulated by the Department.

(h) In the event the Department determines child maltreatment did not occur in a child care facility, nothing in this section shall prevent the Department from citing a violation or issuing an administrative action based upon violations of child care licensure law or rules based upon its investigation. Citations of violations or administrative actions issued pursuant to this subsection shall not be confidential.

(i) During the pendency of an investigation, all matters regarding the investigation, including, but not limited to, any complaint, allegation, or documentation regarding inspections or the identity of the reporter, shall be held in strictest confidence as provided by subjection (j) of this section. Following a determination that maltreatment has occurred, the investigation findings shall be made public, as well as the date of any visits made pursuant to the investigation, and any corrective action taken, if applicable. DCDEE shall not post on its Internet Web site that a maltreatment investigation occurred if the allegation of maltreatment was unsubstantiated.

(j) Regardless of the Department's final determination regarding child maltreatment, all information received by the Department during the course of its investigation shall be held in the strictest confidence by the Department, except for the following:

(1) The Department shall disclose confidential information, other than the identity of the reporter, to any federal, State, or local government entity or its agent in order to protect a juvenile from child maltreatment, abuse, or neglect. Any confidential information disclosed to any federal, State, or local government entity or its agent pursuant to this subdivision shall remain confidential with the other government entity or its agent and shall only be redisclosed for purposes directly connected with carrying out that entity's mandated responsibilities.

(2) The Department shall only disclose information identifying the reporter pursuant to a court order, except that the Department may disclose information identifying the reporter without a court order only to a federal, State, or local government entity that demonstrates a need for the reporter's name to carry out the entity's mandated responsibilities.

(3) A district court, superior court, or administrative law judge of this State presiding over a civil matter in which the Department is not a party may order the Department to release confidential information. The court may order the release of confidential information after providing the Department with reasonable notice and an opportunity to be heard and then determining that the information is relevant, necessary to the trial of the matter before the court, and unavailable from any other source.

(k) When a report of child maltreatment alleges facts that indicate that a report is required under G.S. 7B-301, the Department shall contact the local department of social services in the county where the juvenile resides or is found and make the necessary report.

(l) In performing any duties related to the assessment of a report of child maltreatment, the Department may consult with any public or private agencies or individuals, including the available State or local law enforcement officers, probation and parole officers, and the director of any county department of social services who shall assist in the assessment and evaluation of the seriousness of any report of child maltreatment when requested by the Department. The Department or the Department's representatives may make a written demand for any information or reports, whether or not confidential, that may in the Department's opinion be relevant to the assessment of the report. Upon the Department or the Department's representative's request and unless protected by attorney-client privilege, any public or private agency or individual shall provide access to and copies of this confidential information and the records required by this subsection, to the extent permitted by federal law and regulations.

(m) The North Carolina Child Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section. Rules promulgated subject to this section shall be exempt from the provisions of G.S. 150B-19.1(e) and (f).

"**§ 110-105.4. Duty to report child maltreatment.**

(a) Any person who has cause to suspect that a child in a child care facility has been maltreated, as defined by G.S. 110-105.3, or has died as the result of maltreatment occurring in a child care facility, shall report the case of that child to the Department. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making the report, including (i) the name and address of the child care facility where the child was allegedly maltreated, (ii) the name and address of the child's parent, guardian, or caretaker, (iii) the age of the child, (iv) the present whereabouts of the child if not at the home address, (v) the nature and extent of any injury or condition resulting from maltreatment, and (vi) any other information the person making the report believes might assist in the investigation of the report. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the Department's assessment of the alleged maltreatment.

(b) Upon receipt of any report of maltreatment involving sexual abuse of the child in a child care facility, the Department shall notify the State Bureau of Investigation within 24 hours or on the next workday. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the assessment there is reason to suspect that sexual abuse has occurred, the Department shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report.

"**§ 110-105.5. Child maltreatment registry.**

(a) The Department shall establish and maintain a registry containing the names of all caregivers who have been confirmed by the Department of having maltreated a child pursuant to G.S. 110-105.3.

(b) Individuals who wish to contest findings under subsection (a) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act under Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Child Maltreatment Registry.

(c) Individuals whose names are listed on the Registry shall not be a caregiver as defined in G.S. 110-105.3(b)(2) at any licensed child care facility or religious-sponsored child care facility.

(d) No person shall be liable for providing any information for the Child Maltreatment Registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the Child Maltreatment Registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee. The immunity established by this subsection does not extend to malicious conduct or intentional wrongdoing.

(e) Upon request, a child care facility, as defined in G.S. 110-105.3, is permitted to provide confidential or other identifying information to the Department, including social security numbers, taxpayer identification numbers, parent's legal surname prior to marriage, and dates of birth, for the purpose of verifying the identity of the accused caregiver.

(f) With the exception of the names of individuals listed on the Child Maltreatment Registry, all other information received by or pertaining to the Child Maltreatment Registry shall be confidential and is not a public record under Chapter 132 of the General Statutes.

(g) In order to determine an individual's fitness to care for or adopt a child, information from the Child Maltreatment Registry may be used by any of the Department's divisions responsible for licensing homes or facilities that care for children, and the Department may provide information from this list to child-caring institutions, child-placing agencies, group home facilities, and other providers of foster care, child care, or adoption services.

(h) The North Carolina Child Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

"**§ 110-105.6. Penalties for child maltreatment.**

(a) For purposes of this Article, child maltreatment occurring in child care facilities is a violation of this Article, licensure standards, and licensure laws.

(b) Pursuant to G.S. 110-105.3, when an investigation confirms that child maltreatment did occur in a child care facility, the Department may issue an administrative action up to and including summary suspension and revocation of the facility's child care license.

(c) If the facility is permitted to remain open after an administrative action has been issued, the administrative action shall specify any corrective action to be taken by the operator.

(d) The Department shall make unannounced visits to determine whether the corrective action has occurred. If the corrective action has not occurred, then the Department may take further action against the facility as necessary to protect the health, safety, or welfare of the children at the child care facility.

(e) Administrative actions issued shall include a statement of the reasons for the action and shall specify corrective action that shall be taken by the operator.

(f) Under the terms of the administrative action, the Department may limit enrollment of new children until satisfied the situation giving rise to the confirmation of child maltreatment no longer exists.

(g) Specific corrective action required by an administrative action authorized by this Article may include the removal of the individual responsible for child maltreatment from child

care pending a final determination or appeal of the individual's placement on the Child Maltreatment Registry.

(h) Nothing in this section shall restrict the Department from using any other statutory or administrative remedies available."

SECTION 9. This act becomes effective January 1, 2016.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, April 21, 2015

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

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

SB **371** LME/MCO Claims Reporting.

Draft Number:	S371-PCS25237-SH-25
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Fletcher Hartsell will handle SB 371

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 371
PROPOSED COMMITTEE SUBSTITUTE S371-CSSH-25 [v.4]

4/20/2015 8:19:30 PM

Short Title: LME/MCO Claims Reporting. (Public)

Sponsors:

Referred to:

March 24, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE DATA COLLECTION BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO LME/MCO MANAGED CARE CLAIMS.

Whereas, the Department of Health and Human Services (DHHS) contracts with local management entities/managed care organizations (LME/MCOs) for the management of services for mental health, intellectual and developmental disabilities, and substance abuse disorders; and

Whereas, LME/MCOs are paid to manage Medicaid services on a capitated basis and are at full financial risk for the cost of services delivered through a network of contracted service providers; and

Whereas, LME/MCOs operate pursuant to federal Medicaid managed care rules and have the authority to set rates and utilization rules that are different than fee-for-services payment models; and

Whereas, LME/MCOs also manage State and federal block grant funds under contracts with DHHS; and

Whereas, DHHS requires LME/MCOs to report records of claims payments to providers (encounter data) through NCTracks for both Medicaid and State-funded services; and

Whereas, each LME/MCO has an annual quality review by DHHS, an annual compliance audit by an independent auditor, and two DHHS audits conducted pursuant to S.L. 2013-85 to evaluate the LME/MCO claims processing function for accuracy and completeness; and

Whereas, the results of each LME/MCO's numerous audits are utilized to evaluate quality, ensure operational competence and contract compliance, and verify that all federal Medicaid managed care requirements are met; and

Whereas, DHHS has multiple responsibilities to the Centers for Medicare and Medicaid Services (CMS), to federal authorities for block grants, and to the General Assembly for the proper and accountable expenditure of funds managed by the LME/MCOs in accordance with State and federal requirements, and for the review and audit of encounter data is necessary for the implementation of these responsibilities; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The encounter data submission requirements for local management entities/managed care organizations (LME/MCOs) shall be as follows:

(1) LME/MCOs shall submit to the Department of Health and Human Services (DHHS) encounter data, consisting of records of claims payments made to providers, for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services using a

single nationally recognized, standardized electronic format, which shall be specified to the LME/MCOs in advance to assure compliance with the format of encounter data submitted to the DHHS

(2) DHHS may use encounter data for purposes including, but not limited to, setting LME/MCO capitation rates, measuring the quality of services managed by LME/MCOs, assuring compliance with State and federal regulations, and for oversight and audit functions.

(3) DHHS, pursuant to G.S. 143B-426.38A, shall share encounter data with the Government Data Analytics Center in order to leverage existing public-private partnerships and subject matter expertise that can assist in providing outcomes-based analysis of services and programs as well as population health analytics of the LME/MCO patient population.

(4) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

(5) DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services regarding the status of this section on or before October 31, 2015.

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

4-21-15
Senate Comm on Healthcare

Sergeant-at-Arms

Steve McKaig
Dale Huff

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 4-21 TIME: 11 AM

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

Page Name	Hometown	Sponsoring Senator
1. Emily Braren	Sanford	Rabin
2. Langden Ramsey	Gastonia	Harrington
3.		
4.		
5.		
6.		
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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

SENATE HEALTH CARE COMMITTEE
(Committee Name)

4-21-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
E Patterson, MD	~~Randolph Hospital~~ Mecklenburg Anesthesia public
Lady Sue Ball	public
GERRY COHEN	Nelson Mullins
Chris McClure	BP
Thomas McCormick	City of Raleigh
[signature]	[signature]
Julia Adams Schmidt	ARC/MARC/~~ASNC~~
John Nash	The Arc of NC
Donna Beckmann	5714 Nob Hill Rd Durham, NC
Nancy Line	Public
Lori INGRAM	Public
Karen Simmons	Public
Amy Troy	public
Susan Lotta	Nexsen Pruet
Bill Fulcher	[illegible]
MIKE [illegible]	[illegible]
Kevin LeCount	SEANC

09-21-201

Name

Firm or Agency

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
(Committee Name)

4-21-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Mahan	ASNC
Amy Fulk	30 PR
Mildred Spearman	NCAOC
Lori Ann Harris	~~LAHA~~
Jeff Horton	DHHS - DMA
Mary Buonfiglio	DST
Mary Lewis Cecil	DST
John DelGrando	Brubaker Assoc
Jim Martin	DHHS - DPH
ALAN DELLAPENNA	DPH - TPCB
David Balkcom	DPH - IVPB
Thelma Hayes	NC Board of Nursing
Gene Ainsworth	DMH
	A&A
D.W. Joyner	NCVC
	BCI

09-21-201

Name	Organization
Alex Asbun	DHHS DMH/DD/SAS
Kelly Friedlander	NC Stakeholder [illegible]

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE
(Committee Name)

4-21-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Debbie Clary	NCSP - LME/MCO
Pam Seamans	NC Alliance for Health
Peg O'Connell	March of Dimes
Ken Melton	K. M. A.
[illegible]	AHIP
Allison Stewart	Cardinal
Pamela Shipman	Cardinal Innovations
NICHOLE VARUM	NAMI NC
Matt Gross	NCPC
Annaliese Dolph	DL
Pam Deardorff	NCRSP
[illegible]	DHHS - DCIDD
Alexandra Gruber	DOJ
Trent Womble	DHHS
J Peters	CSS
Curtis McDonald	BMS
Jill Cox	NISNC
Dee Richard	DHHS

09-21-201

Name

Organization

VISITOR REGISTRATION SHEET

Health
(Committee Name)

4/21/15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Starnes	Treasurer
Friedman	S+P
Watts	DST
Harry Lyda	MWC
Hari	DST
Elizabeth Parrish	NCRMA
CS Hall	CSH
Pepper Mayhew	
Chip Baggett	NCMS
Rick Taylor	WM
Erica Nelson	NCHA
Breedon Blackwell	Cape Fear Valley Med. Ctr.
Amanda Hraker	TSS
Joanna Sprull	NCAFP
Macon Gardner	GSIC
JOE LANIER	CARDINAL
Julia R. Hoke	State Education Assistance Authority

Name	Firm or Agency
Tamara Rugfield	
Danielle Blevins	ADRN
Jennifer Gasperini	NCM3
Amy McConkey	NC Bev
Ben Popkin	NCDOI
Steve Monge	NCRLA
JEFF BARNHART	MWC
David McGowan	NCPC
Tracy Kimbrell	Parker Poe
Lexi Morgan	NCRMA
Emily Hawkins	ETOR

Senate Committee on Health Care
Tuesday, April 21, 2015 at 1:00 PM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Health Care met at 1:00 PM on April 21, 2015, in Room 1027/1128 of the Legislative Building. Thirteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing the pages—Esmé Merritt-Dorosin of Orange County, and Alec C. Johnson of Haywood County, and the Sergeants-at-Arms—Terry Barnhardt and Hal Roach.

The purpose of the meeting was to hear presenters on the topic of Certificate of Need. The following each presented to the Committee:

Connie Wilson of Connie Wilson Consulting
Cody Hand of NC Hospital Association
David French of Strategic Healthcare Consultants
Katherine Restrepo of John Locke Foundation

Following the presentations, Senator Apodaca spoke on problems with Certificate of Need and the need for reform. The meeting concluded with discussion and questions on Certificate of Need.

The meeting adjourned at 1:55 PM.

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
Tuesday	April 21, 2015	1:00 PM	1027/1128 LB

No bills have been scheduled. The Committee will hear from a variety of entities on the topic of Certificate of Need.

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

Senate Committee on Health Care
Tuesday, April 21, 2015, 1:00 PM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Introduction of Sergeants-at-Arms

Certificate of Need Presenters

Connie Wilson, Connie Wilson Consulting
Cody Hand, NC Hospital Association
David French, Strategic Healthcare Consultants
Katherine Restrepo, John Locke Foundation

Committee Discussion

Closing Remarks

Adjournment

Problems with Health Planning and Certificate of Need Regulation in North Carolina

David J. French, MBA, MHA
Strategic Healthcare Consultants
Reidsville NC 27320
djfrench45@gmail.com

1) Too many health services in North Carolina are regulated by Certificate of Need ("CON") law. CON laws restricts the entry of new providers, limits patient access to new lower cost providers and stifles innovation in healthcare.

2) Each year, the State Health Coordinating Council provides their recommendations to the Governor in the annual State Medical Facilities Plan. In recent years, the State Medical Facilities Plan is usually approved by the Governor with no amendments

3) The majority of the members of the State Health Coordinating Council ("SHCC") are hospital officials, physicians who are employed or contracted to provide services to hospitals, or are representatives of other healthcare providers that are dependent on hospitals for referrals. Consequently, the SHCC often votes on issues based on what is best for hospitals and not on what is best for the citizens of North Carolina.

4) Many of the methodologies for evaluating the "need" for additional health service capacity in the State Medical Facilities Plan are outdated, inaccurate or incomplete. Data integrity is routinely questioned.

5) Health planning and Certificate of Need regulations are most dysfunctional with regard to ambulatory surgery facilities, operating rooms, and diagnostic centers.

6) There are tremendous potential cost savings associated with shifting ambulatory surgery cases and routine imaging procedures out of hospitals to lower cost non-hospital facilities.

7) Numerous petitions have been submitted to the SHCC regarding operating rooms and ambulatory surgery centers but these are typically denied.

8) The definition of a "diagnostic center" includes a $500,000 threshold that has not been increased since 1993. The CON regulation of diagnostic centers makes it difficult and costly for non-hospital providers to simply relocate or replace existing equipment.

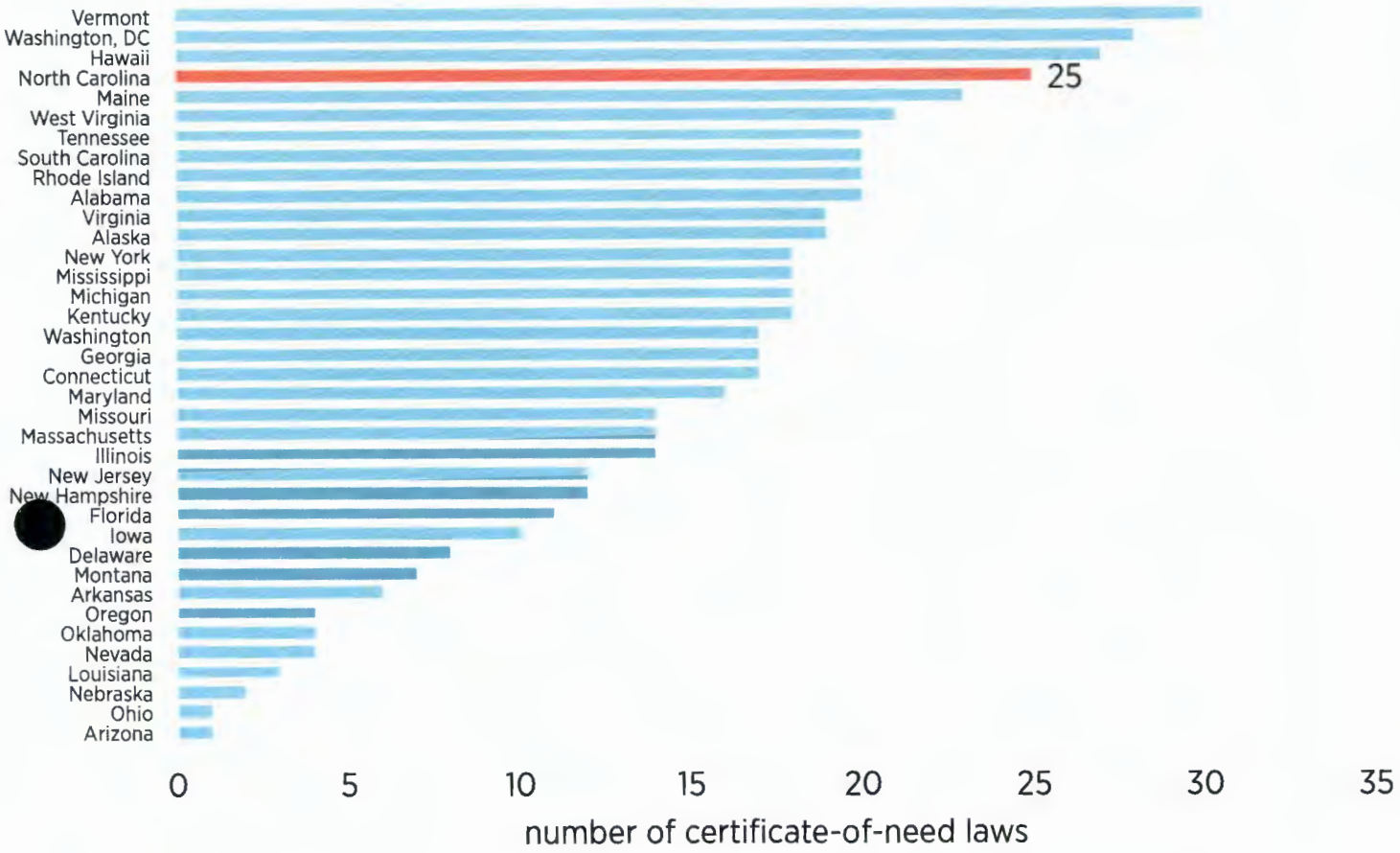
9) Some providers have misused the CON appeals process to block the development of an approved project for years.

10) Incremental CON reform is an alternative to the total repeal of the CON law. However, if North Carolina CON law cannot be modernized then it should be discontinued.

Lower Healthcare Costs *Now!*

Certificate of Need REFORM

Ranking of States by Number of Certificate-of-Need Laws



Note: Fourteen states either have no certificate-of-need laws or they are not in effect. In addition, Arizona is typically not counted as a certificate-of-need state, though it is included in this chart because it is the only state to regulate ground ambulance services.

Source: Christopher Koopman and Thomas Stratmann, "Certificate-of-Need Laws: Implications for North Carolina" (Mercatus on Policy, Mercatus Center at George Mason University, Arlington, VA, February 2015).

MERCATUS CENTER
George Mason University

REFORMCONNOW.com

Estimate Health Care Costs

Enter a treatment or service

ACL Repair by Arthroscopy

Location

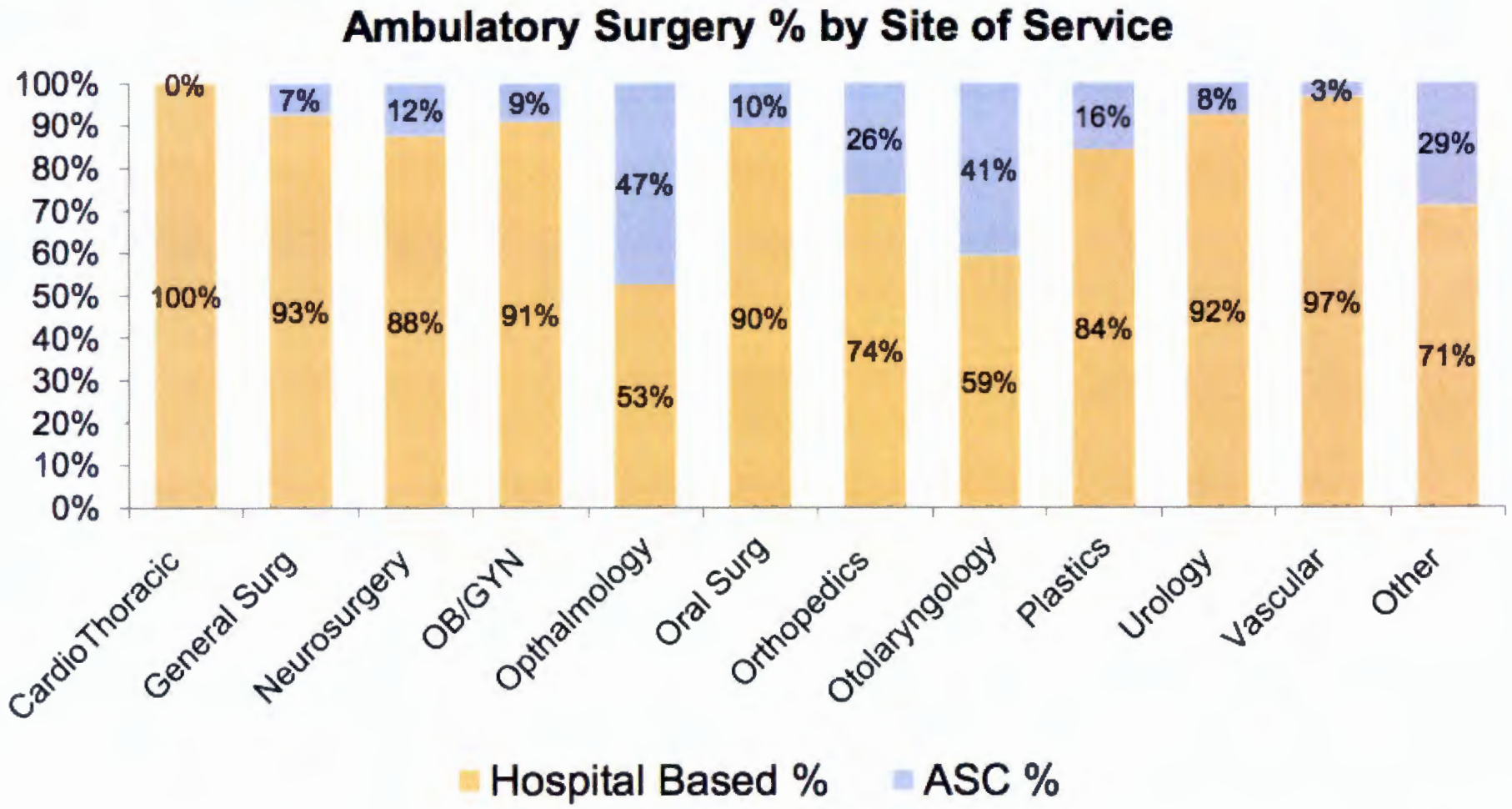
Henderson County, NC

Estimated Treatment Cost Results

Cost estimates are averages based on historical BCBSNC claims data. Amounts listed typically include physician fees, facility fees and costs for things like anesthesia, drugs, medical supplies – as well as customer responsibility (deductible, co-pay and co-insurance). Your actual costs may be different based on variations in these factors as well as your health plan design, deductibles/co-insurance and out-of-pocket limits.

S. David Jarrett **Orthopaedic Surgery Center** 34 Granby St Asheville, NC 28801	Blue Value **$9,002** Blue Options, Blue Advantage **$9,002**
Jay Jansen **Mission Hospital, Inc.** 509 Biltmore Ave Asheville, NC 28801	Blue Value **$11,716** Blue Options, Blue Advantage **$11,716**
Jesse West **Mission Hospital, Inc.** 509 Biltmore Ave Asheville, NC 28801	Blue Value **$12,833** Blue Options, Blue Advantage **$12,833**
Robert Boykin **Mission Hospital, Inc.** 509 Biltmore Ave Asheville, NC 28801	Blue Value **$15,599** Blue Options, Blue Advantage **$15,599**
Charles Depaolo **Mission Hospital, Inc.** 509 Biltmore Ave Asheville, NC 28801	Blue Value **$16,160** Blue Options, Blue Advantage **$16,160**
Andrew Kersten **Park Ridge Health** 100 Hospital Dr Hendersonville, NC 28792	Blue Value **$16,497** Blue Options, Blue Advantage **$16,497**
Richard Jones **Park Ridge Health** 100 Hospital Dr Hendersonville, NC 28792	Blue Value **$18,934** Blue Options, Blue Advantage **$18,934**
Angus Graham **Transylvania Community Hospital** 260 Hospital Dr Brevard, NC 28712	Blue Value **$23,103** Blue Options, Blue Advantage **$23,103**
Christopher Elder **Mission Hospital, Inc.** 509 Biltmore Ave Asheville, NC 28801	Blue Value **$25,039** Blue Options, Blue Advantage **$25,039**

The majority of ambulatory surgery for all specialties is performed in hospital outpatient departments.



Source: Division of Health Service Regulation data, 2014

WINSTON-SALEM JOURNAL

Study: NC regulations drive up health care costs

Richard Craver/Winston-Salem Journal | Posted: Sunday, February 22, 2015 12:00 am

A new study casts a shadow on the effectiveness of North Carolina's certificate-of-need regulations, which determine how many hospitals and health-care services are needed within the state.
The George Mason University study listed North Carolina's CON program as the third most restrictive of the 37 states with such regulations. North Carolina introduced its program in 1978.

A certificate is required before a health-care system or provider can build a medical facility, buy equipment or offer a medical procedure.

The study's authors claim North Carolinians are paying more for services, procedures and equipment because of the CON program.They also claim the program allows systems and providers to charge more in hopes they will use some of the additional revenue to cover otherwise unprofitable, uncompensated charity-care expenses for the poor.

At its essence, CON regulations are meant to prevent unnecessary duplication of services within a community or a region. The goal is preventing oversaturation of services as a means of controlling costs, which as a byproduct helps the majority of systems and providers maintain a healthy revenue stream and market share.

In North Carolina, the CON program has helped fortify not-for-profit health-care systems, such as Cone Health, Novant Health Inc. and Wake Forest Baptist Medical Center. Analysts say the program also has made it more financially challenging to for-profit groups to obtain a meaningful ownership presence in the state.

"By limiting the number of providers that can enter a particular practice, and by limiting the expansion of incumbent providers, CON regulations effectively give a limited monopoly privilege to providers that receive approval in the form of a certificate of need," the authors said. "Approved providers are therefore able to charge higher prices than would be possible under truly competitive conditions. In effect, those who can pay are charged higher prices to subsidize those who cannot."

N.C. near top for regulations
North Carolina's program covers 25 regulated devices and services, ranging from hospitals and ambulatory surgical centers to adult care homes, dialysis centers and medical equipment, such as MRI scanners. Only Vermont, with 30, and Hawaii, with 27, has more regulated devices and services covered by a CON. By contrast, both Arizona and Ohio have one regulated device and service that requires a CON.

The authors determined that states with CON programs have, on average, 131 fewer hospital beds per 100,000 residents. They estimated that based on North Carolina's population of 9.85 million, this could mean 12,900 fewer hospital beds than needed, as well as 49 fewer hospitals offering MRI services and 67 fewer hospitals offering computed tomography (CT) scans.

"It is important to note that CONs were neither designed, nor intended, to ensure public health or ensure that medical professionals have the necessary qualifications to do their jobs," study author Chris Koopman said.

"Separate laws and regulations cover those issues. These programs are solely focused on controlling which providers can compete within a state, as well as when and how they go about it."
Cone and Wake Forest Baptist deferred comment on the study to the N.C. Hospital Association.

Association spokeswoman Julie Henry said she questions the premise, saying there is not a lack of access to hospital health care in North Carolina. "The CON system helps prevent groups from coming in to cherry-pick the most profitable medical procedures that the not-for-profit systems need to maintain a healthy source of excess revenue and to help provide charity care," Henry said.

David Meyer, a senior partner with Keystone Planning Group of Durham, said it is "ludicrous" the authors' finding that there is deficit of 12,900 hospital beds in the state.

"That is the equivalent of 16 800-bed hospitals," Meyer said. "Right now, there are 21,000 acute-care beds with an average occupancy rate of 57 percent. Where would those additional beds and hospitals be needed?

Meyer said only 11 of North Carolina's 111 hospitals do not have a fixed MRI scanner, and nine of those have a mobile scanner. He said he knows of no hospital that does not have a CT scanner. The authors said their study offers legislators and policymakers in North Carolina "a particularly rich opportunity to reverse course and open the market for greater entry, more competition, and ultimately more options for those seeking care."

Legislative fights

Each year, the N.C. Division of Health Service Regulation issues a state medical facilities plan that announces projected infrastructure or equipment needs within a community or region. Health-care systems and providers submit bids to fill the need.

Each request can take several months to more than a year for regulators to approve or deny, with a lengthy appeal process on top of that.Even though in many cases the not-for-profit systems compete against each other, there is an understood concession that it is better to win some and lose some among themselves than to allow for-profit systems to gain a foothold.

"Certificate-of need laws don't necessarily differentiate between in-state and out-of-state providers," the authors said. "Instead, these programs protect incumbent providers from all competition, both in-state and out-of-state. With that said, the practical effect in some instances has been to limit the ability of out-of-state providers to come into a state and compete with in-state providers."

The authors said many states, including North Carolina, justify CON programs "as a way to cross-subsidize health care for the poor. "Under these charity care requirements, providers that receive a certificate are typically required to increase the amount of care they provide to the poor.

"In effect, these programs intend to create quid pro quo arrangements: state governments restrict competition, increasing the cost of health care for some, and in return medical providers use these contrived profits to increase the care they provide to the poor."

In 2013, the state's hospitals fought bills that would have opened them up to competition from lower-cost same-day surgery centers

.

House Bill 177 and Senate Bill 202 would have amended the CON laws to make it easier for doctors to open ambulatory surgery centers. The N.C. Hospital Association contended the bill would benefit a few doctors at the expense of hospitals, but would not cut costs or save state money.

House Bill 177 supporters said the CON program squelches competition and makes routine surgeries more expensive. The bill passed the House by a 112-2 vote, but never emerged from the Senate Committee on Rules and Operations. Senate Bill 202 never came up for a vote.

Triad example

The most vivid Triad example of CON competition occurred between Novant and Wake Forest Baptist. The state Medical Facilities Plan at that time indicated a need for a community hospital in the western Triad.

It took more than two years of heated rhetoric, community pep rallies, economic analyses and several appeals of regulatory CON decisions before the systems agreed in December 2009 to settle their competition for building a 50-bed, $100 million community hospital.

Both hospitals got a conditional CON approval in 2008 through different application cycles. Those approvals both validated and demonstrated the weakness of the CON program since each system proved the need for their facility even though the hospitals are about four miles apart.

Both appealed the decision favoring their rival, citing unnecessary duplication as their main point. "There were times when emotions ran high and some people thought litigation would be the only way to get to the finish line," Greg Beier, then-president of acute-care services for Novant, said in December 2009.

But the realities of legal expenses of more than $1 million a year, and the prospects of seven to 10 years of litigation and appeals, persuaded the systems to reach a compromise.

Each system has built the first phase of its hospital – Clemmons for Novant and Davie for Wake Forest Baptist – each with several hundred employees. Medical offices have been built near each hospital, though hoped-for new commercial investment ripple effect adjacent to either site has not materialized to date.

The systems hedged their construction plans by agreeing not to offer inpatient beds before 2017, which appears fortuitous given both hospitals have had limited usage since opening in 2013.

Bucking the odds

In February 2012, Piedmont Ear Nose and Throat Associates of Winston-Salem opened a $4.1 million outpatient surgery center at 2465 Hanestowne Lane. Piedmont officials are handling about 2,770 cases annually.

The project was part of the state's 2010 Medical Facilities Plan, which identified the need for one specialty ambulatory-surgery facility covering Forsyth and Guilford counties.

In October 2010, Piedmont received a certificate to have two operating rooms for ear, nose and throat surgeries and reconstructive facial plastic surgery for healthy patients needing elective, preventive or therapeutic procedures. The pre-operation, surgical and post-operation areas are within feet of each other.

Dr. Ronald Shealy, the surgical center's medical director, said Piedmont "bucked the odds" in getting the CON because they typically are awarded to large medical centers or their affiliates. It competed with surgical centers proposed by Novant and Wake Forest Baptist.

Shealy said Piedmont has been able to perform some outpatient procedures at "roughly half the cost that it can be in a hospital."

"We get a set fee for the procedure, with no facility fees that the hospitals charge. It's not that we do the procedures better than the hospitals, per se. We're just not incented to be use more or do more. We do the right amount."

Piedmont is participating in a five-year demonstration project to determine whether it's more cost effective to allow physicians' groups to perform certain surgeries in-house rather than in a hospital or outpatient clinic.

As part of the project, Piedmont will provide annual data to the N.C. State Health Coordinating Council on its volume and cost of its outpatient surgeries. It also will be measured on patient outcome, such as wound-infection rates, post-operative infections, post-procedure complications, readmission rates and medication errors.

Shealy said he would encourage state health officials to begin "chipping away at the CON process a bit at a time," introducing more devices and procedures to the same opening bidding as the 2010 ambulatory surgical center need. "If they could one or two a year, it would help reduce overall costs because there would be more competition."

[redacted]raver@wsjournal.com (336) 727-7376

Charity Care for All Other Hospitals in Counties with Over 100,000 Population

The criteria and definitions for self pay / charity / indigent may differ by facility.

Source: 2013 Hospital License Renewal Applications (Self reported data by the hospitals. facility.)

Hospital Name	Ambulatory Surgery	
	# Cases	% of Total
UNC Hospitals	1913	11.1%
Onslow Memorial	476	12.6%
CMC-NorthEast	536	8.0%
North Carolina Baptist	1271	6.3%
Vidant Medical Center	537	6.1%
WakeMed	806	5.9%
Carolinas Medical Center	851	5.6%
Randolph Hospital	133	5.3%
Catawba Memorial Hospital	290	5.1%
Iredell Memorial	208	5.1%
High Point Regional	165	4.9%
Cone Health	805	4.7%
Southeastern Regional	209	4.7%
Cleveland Regional	188	4.6%
Cape Fear Valley Medical Center	283	4.5%
Presbyterian Hospital Huntersville	148	4.4%
Wayne Memorial	316	4.3%
CMC-Union	202	4.2%
New Hanover Regional	710	4.1%
Gaston Memorial	343	3.7%
Presbyterian Hospital Matthews	163	3.7%
Durham Regional	120	3.7%
Margaret Pardee Memorial	174	3.6%
Lexington Medical Center	195	3.5%
Thomasville Medical Center	125	3.4%
Park Ridge Health	152	3.4%
North Carolina Specialty Hospital	166	3.3%
Davis Hospital	47	3.2%
First Health Moore Regional	138	3.1%
Brunswick Community	91	3.1%
Alamance Regional	231	3.1%
Duke University Hospital	661	3.1%
CMC-Mercy/Pineville	313	3.0%
Presbyterian Orthopaedics	114	2.8%
Forsyth Memorial Hospital	385	2.7%
CMC-University	178	2.5%
Mission Hospitals	531	2.5%
Johnston Memorial	114	2.5%
Medical Park	233	2.4%
J. Arthur Dosher Hospital	25	2.4%
WakeMed Cary	123	2.3%
Rowan Regional	163	2.3%
Presbyterian Hospital	345	2.2%
CarolinaEast Medical Center (Craven)	214	2.2%
Betsy Johnson	45	1.8%
Rex Hospital	304	1.8%
Duke Raleigh	195	1.6%
Frye Regional	126	0.5%
Lake Norman Regional	28	0.5%
		Average 3.91%

Research Regarding ASC's and Hospitals by State

24 States Do Not Have CON Laws Regulating ASC's

States	# ASCs	# Hospitals	CON Regulation of ASCs	2012 Population	ASCs per 100,000 Population	Hospitals per 100,000 Population	Does State Have CON Laws
Alabama	42	93	Yes	4,822,023	0.871	1.93	Yes
Alaska	15	12	Yes	731,449	2.051	1.64	Yes
Arizona	165	73	No	6,553,255	2.518	1.11	No
Arkansas	60	50	No	2,949,131	2.034	1.70	Yes
California	754	356	No	38,041,430	1.982	0.94	No
Colorado	120	53	No	5,187,582	2.313	1.02	No
Connecticut	61	34	Yes	3,590,347	1.699	0.95	Yes
Delaware	17	8	Yes	917,092	1.854	0.87	Yes
Florida	606	213	No	19,317,568	3.137	1.10	Yes
Georgia	341	115	Yes	9,919,945	3.438	1.16	Yes
Hawaii	20	13	Yes	1,392,313	1.436	0.93	No
Idaho	51	17	No	1,595,728	3.196	1.07	No
Illinois	144	142	Yes	12,875,255	1.118	1.10	Yes
Indiana	130	97	No	6,537,334	1.989	1.48	Yes
Iowa	25	40	Yes	3,074,186	0.813	1.30	No
Kansas	71	61	No	2,885,905	2.460	2.11	Yes
Kentucky	39	77	Yes	4,380,415	0.890	1.76	Yes
Louisiana	109	112	No	4,601,893	2.369	2.43	Yes
Maine	17	22	Yes	1,329,192	1.279	1.66	Yes
Maryland	325	50	Yes	5,884,563	5.523	0.85	Yes
Massachusetts	59	81	Yes	6,646,144	0.888	1.22	Yes
Michigan	122	109	Yes	9,883,360	1.234	1.10	Yes
Minnesota	65	56	No	5,379,139	1.208	1.04	No
Mississippi	69	73	Yes	2,984,926	2.312	2.45	Yes
Missouri	109	89	No	6,021,988	1.810	1.48	Yes
Montana	18	15	Yes	1,005,141	1.791	1.49	Yes
Nebraska	48	30	No	1,855,525	2.587	1.62	Yes
Nevada	60	28	Yes	2,758,931	2.175	1.01	Yes

New Hampshire	29	14	Yes	1,320,718	2.196	1.06	Yes
New Jersey	168	75	No	8,864,590	1.895	0.85	Yes
New Mexico	24	40	No	2,085,538	1.151	1.92	Yes
New York	116	202	Yes	19,570,261	0.593	1.03	Yes
North Carolina	118	106	Yes	9,752,073	1.210	1.09	Yes
North Dakota	12	11	No	699,628	1.715	1.57	No
Ohio	201	152	No	11,544,225	1.741	1.32	Yes
Oklahoma	48	102	No	3,814,820	1.258	2.67	Yes
Oregon	92	38	No	3,899,353	2.359	0.97	Yes
Pennsylvania	297	183	No	12,763,536	2.327	1.43	No
Rhode Island	9	12	Yes	1,050,292	0.857	1.14	Yes
South Carolina	75	66	Yes	4,723,723	1.588	1.40	Yes
South Dakota	19	28	No	833,354	2.280	3.36	No
Tennessee	156	119	Yes	6,456,243	2.416	1.84	Yes
Texas	434	385	No	26,059,203	1.665	1.48	No
Utah	81	37	No	2,855,287	2.837	1.30	No
Vermont	1	7	Yes	626,011	0.160	1.12	Yes
Virginia	51	92	Yes	8,185,867	0.623	1.12	Yes
Washington	288	64	Yes	6,897,012	4.176	0.93	Yes
West Virginia	9	37	Yes	1,855,413	0.485	1.99	Yes
Wisconsin	74	78	No	5,726,398	1.292	1.36	Yes
Wyoming	17	13	No	576,412	2.949	2.26	No

***Note*: Some of the numbers reflect the state-licensed facilities, whereas others reflect the total number of facilities in that state. Usually, those states with the total number of facilities do not have licensing requirements for ASCs.**

[1] **Ariz. has 165 Medicare-certified ASCs.**

[2] **Includes state licensed and certified facilities**

[3] **W.Va. has nine Medicare-certified ASCs. ASCs are not licensed in W.Va.**

Sources:

Gordon, Dani, "How many licensed ASCs are in your state?", Becker's Hospital Review, August 28, 2014

National Conference of State Legislures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

World Atlas, Interactive List of US States (2012 populations) http://www.worldatlas.com/aatlas/populations/usapoptable.htm

American Hospital Directory, http://www.ahd.com/states/hospital_AK.html

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 21, 2015
1:00 pm

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
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Jacqueline Scott	" "
Dorothy Riguera	"
Sarah Free	" "
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Katie McKittrick	Duke Medicine
Michael Lister	Duke Nursing
Mary Trony	Pitt Community College ADN
Brooke Chamblee	Pitt community college - Nursing
Robyn Rayner	Pitt community college - Nursing, Greenville
Karen Lemmons	public
Mary Holland	public
Frances Shingleton NK	Public.
Lori Ingram	NCNA / Public

09-21-201

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Jennicfer Pugi-Mulay	Cape Fealy Valley Med. Center
Stephanie M. Dove	Cape Fear Valley Medical Center
Allison H Strickland	Cape Fear Valley - Bladen Healthcare
Amber Oholar RN	Cape Fear Valley - Bladen Healthcare
Teresa Phipps BSN-RN	Cape Fear valley - Bladen Healthcare
Tiffany Pait	CFV Bladen Healthcare
Jennifer Maynard	Bladen Healthcare - CFVHS
Patricia Smith	Bladen Healthcare - CFVHS
Nallatie Gore	Bladen Healthcare CFVHS
Christina Lamb	Bladen Healthcare - CFVHS
Karen Stein	CFVHS - Hoke Hospital
Lori Kroll	Novant Health
Breeden Blackwell	UCHA
Anita Bandumuga	Cape Fear Valley Hosp. System
Lauren Tate RN	Cape Fear Valley Health System
Carol Butler, FNP-C	Cape Fear Valley - Bladen Healthcare
Laurie Orario	LALC
Joey Nichols	Orthocarolina
LEUA Fitness	Cape Fear Valley Med Center Rep.

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Nancy Line, RN	Public
Sharon McNamara RN	Public
Margaret Fleischhauer RN	Public
Misha Price	Duke School of Nursing
Suzanne Frisbee	Duke School of Nursing
Susan Lotta	Hansen Pruet
Lori Taylor, RN	Bladen Healthcare - Cape Fear Valley
[illegible]	Bladen Healthcare - Cape Fear Valley
Beth Dempster, RN	Cape Fear Valley Medical Center

09-21-201

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Senate Committee on Health Care

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1:00 pm

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NAME	FIRM OR AGENCY AND ADDRESS
Hannah White	PCC Nursing School, Greenville NC
Amanda Tucker	Pitt Community College - Nursing Winterville NC
Carol Meyer	The Carolinas Center for Hospice
Jennifer Gasparini	NCMS
Stephanie Douglass	Watts School of Nursing
S. Marriott	WSON
Chelsey Gibbs	Pitt community college
Meredith Edwards	Pitt Community College - Nursing
Ashley Hurley	Randolph Hospital Asheboro, NC
Chelsee Freeman	Randolph Hospital - Asheboro, NC
Kimberly Delgado, RN	204 GREENBRIAR DRIVE GREENVILLE, NC 27834
KEVIN LECOUNT	SEANC
HUGH TILSON	NCHA

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 21, 2015
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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
	MWC
Beth Langley, RN	Cape Fear Valley Health System 1608 Owen Dr Fayetteville, NC 28302
Carole Baggett, RN	Harnett Health System 28334 600 Tilghman Dr. Dunn NC
Cody Hand	NCHA
Richard Strucl, MD	TRIANGLE GASTROENTEROLOGY ASSOCIATES, PA
Kerra Bolton	WTM
Christine Craig	WakeMed
Daniel VanLiere	Vidant Health
Lanior Swann Hodgson	UNC Health Care
Donna Powell, RN	Cape Fear Valley Health System 1608 Owen Dr., Fayetteville, NC 28302
Amanda Heraker	Tradmor Sanders
Joni Sloan RN-BC	NORTH CAROLINA NURSES ASSOCIATION
Teresa Greene	CAROLINAS HEALTH CARE
Tommy Stevens	Stevens Lobby/Consulting
K.D Sturgis	AG's office
R. Buffett Ivey	Mission Health -
Mahmoud Kaddoura	Duke University

09-21-201

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NAME	FIRM OR AGENCY AND ADDRESS
Diane Uzarski DNP	Duke University
Maitland McConnell	Carolinas HealthCare Sys
Tracy Kimbrell	Parker Poe
Ryan Blackledge	Cone Health
Chris Evans	BCBSNC
Kathryn Millican	BCBSNC
David Bolhacker	NC Board of Nursing
Jessie Goodman	DHHS/DHSR
Martha Frisone	DHHS/DHSR
Chris Yaple	DHHS/NCMCC
Kristin Wainwright	Duke University - Nursing
Margie Molloy	Duke University School of Nursing
Crystal Lamarre	Watts School of Nursing
Langstreet Keans	Watts School of Nursing
Barbara Dotson	Watts School of Nursing
Ashley Miller	Watts School of Nursing
[illegible] Lee Reid	Watts School of Nursing

09-21-201

Senate Committee on Health Care
Monday, April 27, 2015 at 5:00 pm
544 Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 5:00 pm on April 27, 2015, in room 544 of the Legislative Office Building. Fourteen members were present.

Senator Tommy Tucker, Chair, presided.

Senator Tucker opened by the meeting by welcoming everyone and recognizing the Senate Sergeant-at-Arms – Giles Jeffreys and Anderson Meadows.

Senator Tucker announced that SB 405, sponsored by Senator Rick Gunn, would be for discussion only.

Senator Tucker recognized Senator Hartsell to present Senate Bill 363. Senator Hise moved for approval of a proposed committee substitute which passed by voice vote. Senators Woodard, Wade, Rabin, Tucker, McKissick, Lowe and Pate raised questions and discussed the bill. Larry Michael with the North Carolina Department of Health and Human Services also spoke and answered questions concerning the bill. Senator Lowe moved for an unfavorable report for the bill, but favorable report as to committee substitute bill with a sequential referral to the Commerce Committee. The motion passed favorably by voice vote.

Senator Tucker recognized Senator Don Davis to present Senate Bill 598. Senator Lowe moved for approval of a proposed committee substitute which passed by voice vote. Adam Sholar with the NC Department of Health and Human Services spoke on the bill along with discussions by Senators Hise and Wade. Senator McKissick moved for a unfavorable report as to the bill, but favorable report as to the committee substitute with a sequential referral to the State and Local Government Committee. The motion passed favorably by voice vote.

The meeting adjourned at 5:34 pm.

Tommy Tucker

Senator Tommy Tucker
Presiding

Joey Stansbury
Committee Clerk

Senate Committee on Health Care
Monday, April 27, 2015, 5:00 PM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 363	Expand Outdoor Food Service at Public Events.	Senator Hartsell
SB 405	Track Sudden Unexplained Death in Epilepsy.	Senator Gunn
SB 598	Reporting of Substance-Exposed Newborns.	Senator D. Davis Senator Pate Senator B. Jackson

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Monday, April 27, 2015

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

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

SB **598** Reporting of Substance-Exposed Newborns.

Draft Number:	S598-PCS45359-TK-35
Sequential Referral:	State and Local Government
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Donald Davis will handle SB 598

CMR265-V-1

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Monday, April 27, 2015

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

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

SB **363** Expand Outdoor Food Service at Public Events.

Draft Number:	S363-PCS35272-SH-33
Sequential Referral:	Commerce
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Fletcher Hartsell will handle SB 363

SENATE BILL 363:
Expand Outdoor Food Service at Public Events

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Commerce	**Date:**	April 25, 2015
Introduced by:	Sen. Hartsell	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition S363-CSSH-33		

SUMMARY: Senate Bill 363 allows pushcarts or mobile food units to prepare and serve food on the premises provided they are based from a permitted commissary or restaurant that is located on the premises of a facility containing at least 3,000 permanent seats.

[As introduced, this bill was identical to H440, as introduced by Rep. Setzer, which is currently in House Regulatory Reform.]

CURRENT LAW/RULES:

15A NCAC 18A.2651 provides the following definitions:

Mobile food unit - a food establishment or pushcart designed to be readily moved to vend food.

Pushcart – a mobile piece of equipment or vehicle used to vend food.

Commissary – a food establishment that services a mobile food unit or a pushcart

Restaurant – a food establishment that prepares or serves food and provides seating.

15A NCAC 18A .2670 provides general requirements for pushcarts and mobile food units.

15A NCAC 18A .2671 provides specific requirements for pushcarts.

15A NCAC 18A .2672 provides specific requirements for mobile food units

BILL ANALYSIS: Senate Bill 363 allows pushcarts or mobile food units to prepare and serve food on the premises provided they are based from a permitted commissary or restaurant that is located on the premises of a facility containing at least 3,000 permanent seats.

- Raw meat, poultry, and fish must be prepared in a permitted commissary or restaurant in pre-portioned or ready-to-cook form. Pushcarts or mobile food units that handle raw ingredients must be equipped with a handwashing sink.
- Open food and utensils must be provided with overhead protection or otherwise equipped with individual covers such as domes, chafing lids, or cookers with hinged lids.
- Food equipment and supplies must be located in enclosed areas and protected from environmental contamination when not in operation.

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

O. Walker Reagan
Director

S363-SMSH-53 CSSH-33 -V2

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 363
PROPOSED COMMITTEE SUBSTITUTE S363-CSSH-33 [v.5]

4/25/2015 12:59:11 PM

Short Title: Expand Outdoor Food Service at Public Events. (Public)

Sponsors:

Referred to:

March 24, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING PUSHCARTS OR MOBILE FOOD UNITS TO PREPARE AND SERVE FOOD ON THE PREMISES PROVIDED THEY ARE BASED FROM A COMMISSARY OR RESTAURANT LOCATED ON THE PREMISES OF A FACILITY CONTAINING 3,000 PERMANENT SEATS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248(c1) reads as rewritten:

"(c1) The Commission shall adopt rules governing the sanitation of pushcarts and mobile food units. A permitted restaurant or commissary shall serve as a base of operations for a pushcart. A mobile food unit shall meet all of the sanitation requirements of a permitted commissary or shall have a permitted restaurant or commissary that serves as its base of operation. Pushcarts or mobile food units that are based from a permitted commissary or restaurant that is located on the premises of a facility which contains at least 3,000 permanent seats shall be allowed to prepare and serve food on the premises. Raw meat, poultry, and fish shall be prepared in a permitted commissary or restaurant in a pre-portioned or ready-to-cook form. Pushcarts or mobile food units that handle raw ingredients shall be equipped with a handwashing sink. All open food and utensils shall be provided with overhead protection or otherwise equipped with individual covers, such as domes, chafing lids, or cookers with hinged lids. Food equipment and supplies shall be located in enclosed areas and protected from environmental contamination when not in operation."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SENATE BILL 363

Short Title:	Expand Outdoor Food Service at Public Events.	(Public)
Sponsors:	Senators Hartsell (Primary Sponsor); and Waddell.	
Referred to:	Rules and Operations of the Senate.	

March 24, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING A VARIANCE FROM RULES GOVERNING THE SANITATION OF PUSHCARTS AND MOBILE FOOD UNITS IN ORDER TO EXPAND PORTABLE, OUTDOOR FOOD PREPARATION WITHOUT ENCLOSURE FOR FOOD SERVICE TO THE PUBLIC.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130-248(c1) reads as rewritten:

"(c1) The Commission shall adopt rules governing the sanitation of pushcarts and mobile food units. A permitted restaurant or commissary shall serve as a base of operations for a pushcart. A mobile food unit shall meet all of the sanitation requirements of a permitted commissary or shall have a permitted restaurant or commissary that serves as its base of operation. The Department of Health and Human Services may grant a variance from the rules governing the sanitation of pushcarts, mobile food units, or both for the purpose of expanding portable, outdoor food preparation without enclosure for food service to the public. The Department may impose reasonable and appropriate conditions and safeguards upon any variance it grants."

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

SENATE BILL 405:
Track Sudden Unexplained Death in Epilepsy

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Judiciary II	**Date:**	April 27, 2015
Introduced by:	Sen. Gunn	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate bill 405 requires the Office of the Chief Medical Examiner to train medical examiners how to recognize sudden unexplained death in epilepsy and to investigate whether it is a known or suspected cause of death in each case under its jurisdiction.***

CURRENT LAW:

A medical examiner makes inquiries regarding the cause and manner of death for each body in his or her charge. A medical examiner is required to reduce the findings to writing and make a full report to the Chief Medical Examiner. In doing so, the medical examiners are authorized to inspect and copy medical records of the decedent. Medical examiners are also authorized to inspect all physical evidence and documents which may be relevant to the death. Upon completion of the investigation, the medical examiner is required to complete a death certificate, which includes the cause, means or manner of death, including if such a cause, means, or manner is undeterminable.

BILL ANALYSIS:

Section 1 of Senate bill 405 would add to the powers and duties of the Chief Medical Examiner, enumerated under G.S. 130A-379 the following:

- Establish a sudden unexplained death in epilepsy (SUDEP) awareness training program to educate all medical examiners in this State about SUDEP and how to investigate whether SUDEP is a known or suspected cause of death.

Section 2 of Senate bill 405 would require, for each death under investigation, the Chief Medical Examiner's inquiries regarding cause and manner of death to include an inquiry to determine whether the death was a direct result of a seizure or epilepsy. If the findings of an autopsy are consistent with sudden unexplained death in epilepsy, the Chief Medical Examiner would be required to do all of the following:

- Indicate on the death certificate that SUDEP is the cause or suspected cause of death.
- Request that the decedent's authorized representative submit relevant medical information about the decedent to a SUDEP registry for research purposes.

Request that a person authorized to make an anatomical gift of the decedent's body or body part consider making a gift of the decedent's brain for research or educational purposes.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

BACKGROUND: According to the Epilepsy Foundation, SUDEP "is said to occur when a person with epilepsy dies unexpectedly and was previously in their usual state of health. The death is not known to be related to an accident or seizure emergency such as status epilepticus. When an autopsy is done, no

other of cause of death can be found. Each year, more than 1 out of 1,000 people with epilepsy die from SUDEP." [1]

[1] http://www.epilepsy.com/sudep-institute

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SENATE BILL 405

Short Title:	Track Sudden Unexplained Death in Epilepsy.	(Public)
Sponsors:	Senators Gunn (Primary Sponsor); Foushee, Hise, Randleman, Robinson, and Smith-Ingram.	
Referred to:	Rules and Operations of the Senate.	

March 25, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING THE OFFICE OF THE CHIEF MEDICAL EXAMINER TO TRAIN MEDICAL EXAMINERS HOW TO RECOGNIZE SUDDEN UNEXPLAINED DEATH IN EPILEPSY (SUDEP) AND TO INVESTIGATE WHETHER SUDEP IS A KNOWN OR SUSPECTED CAUSE OF DEATH IN EACH CASE UNDER ITS JURISDICTION.

Whereas, sudden unexplained death in epilepsy (SUDEP) is a mysterious, rare condition in which typically young or middle-aged individuals with epilepsy die without a clear cause; and

Whereas, SUDEP is generally defined by the medical community as a sudden, unexplained, nontraumatic, nondrowning death in an otherwise healthy individual with epilepsy, where the postmortem examination does not reveal an anatomical or toxicological cause for the death; and

Whereas, SUDEP is believed to account for up to seventeen percent (17%) of deaths in people with epilepsy; and

Whereas, autopsy plays a key role in determining the diagnosis of SUDEP, yet the Institute of Medicine has found that SUDEP may be underreported for several reasons, including a lack of awareness about SUDEP among medical examiners; and

Whereas, the cause of SUDEP is not known and opportunities for its prevention have been hindered by the lack of a systematic effort to collect information about persons who have died from SUDEP, as is done with many other disorders; and

Whereas, it is appropriate to raise awareness of SUDEP among medical examiners by developing a SUDEP awareness program and to facilitate research into the causes and prevention of SUDEP by requiring that medical examiners in this State who determine that an individual's cause of death is SUDEP request from the individual's survivors that the individual's relevant medical information be sent to a SUDEP registry and that the individual's brain be donated for research purposes; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-379 reads as rewritten:

"**§ 130A-379. ~~Duties~~ Powers and duties of the Chief Medical Examiner.**

(a) The Chief Medical Examiner shall ~~perform~~do all of the following:

(1) Perform postmortem medicolegal examinations as provided in this Part.

(2) Establish a sudden unexplained death in epilepsy (SUDEP) awareness training program to educate all medical examiners in this State about SUDEP and how to investigate whether SUDEP is a known or suspected cause of death.

(b) The Chief Medical Examiner may, upon request, provide instruction in health science, legal medicine and other subjects related to his duties at The University of North Carolina, the North Carolina Justice Academy and other institutions of higher learning."

SECTION 2. G.S. 130A-385 reads as rewritten:

"**§ 130A-385. Duties of medical examiner upon receipt of notice; reports; copies.**

(a) Upon receipt of a notification under G.S. 130A-383, the medical examiner shall take charge of the body, make inquiries regarding the cause and manner of death, reduce the findings to writing and promptly make a full report to the Chief Medical Examiner on forms prescribed for that purpose.

(a1) For each death under investigation, the Chief Medical Examiner's inquiries regarding the cause and manner of death shall include an inquiry to determine whether the death was a direct result of a seizure or epilepsy. If the findings of an autopsy are consistent with the definition of known or suspected sudden unexplained death in epilepsy, the Chief Medical Examiner shall do all of the following:

(1) Indicate on the death certificate that sudden unexplained death in epilepsy is the cause or suspected cause of death.

(2) Request that the decedent's authorized representative submit relevant medical information about the decedent, consistent with the federal Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164, to a sudden unexplained death in epilepsy registry for research purposes.

(3) Request that a person authorized to make an anatomical gift of the decedent's body or body part under G.S. 130A-412.11 consider making an anatomical gift of the decedent's brain to maximize the opportunity for research or education on sudden unexplained death in epilepsy.

(a2) The Chief Medical Examiner or the county medical examiner is authorized to inspect and copy the medical records of the decedent whose death is under investigation. In addition, in an investigation conducted pursuant to this Article, the Chief Medical Examiner or the county medical examiner is authorized to inspect all physical evidence and documents which may be relevant to determining the cause and manner of death of the person whose death is under investigation, including decedent's personal possessions associated with the death, clothing, weapons, tissue and blood samples, cultures, medical equipment, X rays and other medical images. The Chief Medical Examiner or county medical examiner is further authorized to seek an administrative search warrant pursuant to G.S. 15-27.2 for the purpose of carrying out the duties imposed under this Article. In addition to the requirements of G.S. 15-27.2, no administrative search warrant shall be issued pursuant to this section unless the Chief Medical Examiner or county medical examiner submits an affidavit from the office of the district attorney in the district in which death occurred stating that the death in question is not under criminal investigation.

(a3) The Chief Medical Examiner shall provide directions as to the nature, character and extent of an investigation and appropriate forms for the required reports. The facilities of the central and district offices and their staff services shall be available to the medical examiners and designated pathologists in their investigations.

(b) The medical examiner shall complete a certificate of death, stating the name of the disease which in ~~his~~ the medical examiner's opinion caused death. If the death was from external causes, the medical examiner shall state on the certificate of death the means of death, and whether, in the medical examiner's opinion, the manner of death was accident, suicide, homicide, execution by the State, or undetermined. The medical examiner shall also furnish any information as may be required by the State Registrar of Vital Statistics in order to properly classify the death.

(c) The Chief Medical Examiner shall have authority to amend a medical examiner death certificate.

(d) A copy of the report of the medical examiner investigation may be forwarded to the appropriate district attorney.

(e) In cases where death occurred due to an injury received in the course of the decedent's employment, the Chief Medical Examiner shall forward to the Commissioner of Labor a copy of the medical examiner's report of the investigation, including the location of the fatal injury and the name and address of the decedent's employer at the time of the fatal injury. The Chief Medical Examiner shall forward this report within 30 days of receipt of the information from the medical examiner.

(f) If a death occurred in a facility licensed subject to Article 2 or Article 3 of Chapter 122C of the General Statutes, or Articles 1 or 1A of Chapter 131D of the General Statutes, and the deceased was a client or resident of the facility or a recipient of facility services at the time of death, then the Chief Medical Examiner shall forward a copy of the medical examiner's report to the Secretary of Health and Human Services within 30 days of receipt of the report from the medical examiner."

SECTION 3. This act becomes effective October 1, 2015.

SENATE BILL 598:
Reporting of Substance-Exposed Newborns

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to State and Local Government	**Date:**	April 27, 2015
Introduced by:	Sens. D. Davis, Pate, B. Jackson	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	PCS to First Edition S598-CSTK-35		

SUMMARY: The PCS to Senate Bill 598 requires the Department of Health and Human Services to adopt rules pertaining to development of protection plans for substance-exposed newborns and the conduct of child protective services assessments for those newborns.

BILL ANALYSIS:

The PCS to Senate Bill 598 would require county departments of social services to follow rules adopted by the Department of Health and Human Services regarding the development of protection plans for, and child protective services assessments of, substance-exposed newborns. County departments would be required to use structured decision-making tools as well as family service agreements for substance-exposed newborn cases. These tools and agreements would be required to ensure the well-being of the newborn and a safe living environment for the newborn. The family service agreements would be required to address the following:

- The newborn's need for medical care appointments.
- Access to, and cooperation with, health care resources.
- The parent's participation in substance abuse treatment.
- The need for routine substance abuse screening.
- Visitation planning if the newborn is placed out of the home.

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

BACKGROUND: Federal law requires that reports of children born with positive toxicology for illegal substances must be accepted for child protective services assessment. This prenatal exposure to illegal substances is addressed in the North Carolina Division of Social Services Family Services Manual under Enhanced Practice for Working with Special Populations.[1]

[1] http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/pdf%20docs/CS1440.pdf

O. Walker Reagan
Director

S598-SMTK-60 CSTK-35 -V2

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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SENATE BILL 598
PROPOSED COMMITTEE SUBSTITUTE S598-CSTK-38 [v.2]

4/24/2015 4:38:27 PM

Short Title: Substance-Exposed Newborns Protection Plans. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP PROTOCOLS ADDRESSING SUBSTANCE-EXPOSED NEWBORN CHILD PROTECTIVE SERVICES CASES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall develop and make available for use by the county departments of social services, protocols for the development of protection plans for substance-exposed newborns and the conduct of child protective services assessments of those newborns when an assessment is warranted. The protocols shall include the use of structured decision-making tools and family services agreements for substance-exposed newborn cases to ensure the well-being of the newborn and a safe living environment for the newborn. The family services agreements shall also address any applicable issues, including, but not limited to, the following:

(i) The newborn's need for medical care appointments.
(ii) Access to, and cooperation with, health care resources.
(iii) The parent's participation in substance abuse treatment.
(iv) The need for routine substance abuse screenings.
(v) Visitation planning if the newborn is placed out of the home.

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

SENATE BILL 598

Short Title:	Reporting of Substance-Exposed Newborns.	(Public)
Sponsors:	Senators D. Davis, Pate, B. Jackson (Primary Sponsors); and Hartsell.	
Referred to:	Rules and Operations of the Senate.	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE USE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF SOCIAL SERVICES, POLICIES REGARDING APPROACHES TO ADDRESSING THE REPORTING OF SUBSTANCE-EXPOSED NEWBORNS.

The General Assembly of North Carolina enacts:

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

"**§ 7B-300A. Reporting of substance-exposed newborns.**

(a) The General Assembly recognizes that there are instances when children are born having been exposed to addictive substances and that such situations may require a child protective services social worker to approach the situation with certain sensitivities and a level of awareness of this special population of children. For purposes of this section, "special population" refers to children who are at greater risk because of various physical, emotional, cultural, or environmental factors that make children more vulnerable to abuse or less able to communicate their fears.

(b) To that end, county departments of social services shall use the policies developed from time to time by the Department of Health and Human Services, Division of Social Services, regarding the development of protection plans for substance-exposed newborns and the conduct of child protective services assessments of those newborns, when based on various factors, an assessment is warranted. Further, pursuant to the policies set forth by the Division, county departments of social services shall use the structured decision-making tools and family services agreements throughout the life of substance-exposed newborn cases to ensure the well-being of the newborn and a safe living environment for the newborn, as well as address any other issues regarding the newborn, including, but not limited to, (i) the need for medical care appointments, (ii) access and cooperation with health care resources, (iii) the parent's participation in substance abuse treatment, (iv) the need for routine substance abuse screenings, and (v) visitation planning if the child is placed out of the home."

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

VISITOR REGISTRATION SHEET

Senate Health Care Committee — April 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Doug Miskew	PSG
Evelyn Hawthorne	EHOR
Annaliese Dolph	DL
Jennifer Mahan	ASNC
[illegible]	DHHS
Chuck Greene	AT+T
Larry Michael	DHHS
Trent Womble	DHHS
[illegible]	MP
TJ Bugbee	NP
Rob Lamme	PSA

VISITOR REGISTRATION SHEET

Senate Health Care Committee — April 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Joanna Spruill	NCAFP
Kara Weishaar	SA
Cory Hapb	NC HA
Amanda Horaker	TSS
Allison Stewart	Cardinal Innovations
Jeff Barnhart	MWC
Pat O. Yancey	APPCNC
Sara	Duke Energy
Lexi Morgan	NCRMA

Senate Sergeant-at-Arms

Giles Jeffreys

Anderson Meadows

Senate Committee on Health Care
Tuesday, May 12, 2015 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 12, 2015 in Room 544 of the Legislative Office Building. Eighteen members were present; Senator Louis Pate presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Donna Blake, Hal Roach and Steve Wilson. He then introduced the Pages: Brandon Wallace of Nashville, Deonte' McKenney of Fayetteville, Qy'Darrius McEachern of Lumberton, Rachel Gore of Wilmington, and Elizabeth White of Deep Gap.

Senator Pate welcomed and introduced the family of former Representative Jim Fulghum. They were in attendance for HB 158 - the "Jim Fulghum Teen Skin Cancer Prevention Act" to be discussed in the meeting.

Senator Apodaca was then recognized to explain HB 195 – "Allow Substitution of Biosimilars." After several questions and answers, Senator Bingham moved for a favorable report; the motion carried.

Senator Tucker was recognized next to explain HB 158 – "Jim Fulghum Teens Skin Cancer Prevention Act." Representative Hurley also made comments regarding the bill. Two members of the audience, Diana McShane who is a Pediatric Dermatologist, spoke in favor of the bill. Michael Houser of the Indoor Tanning Association spoke against the bill. Senator Lowe moved for a favorable report; motion carried.

Representative Dobson explained HB 437 – "Create Permit Exemptions/Home Renal Products." He explained in detail and answered several questions. Afterward, Senator Hise moved for a favorable report. Motion carried.

Lastly, Senator Pate recognized Dr. Mary Susan Fulghum who thanked everyone for their efforts regarding this bill. She spoke at length about how Dr. Fulghum had been passionate about preventing skin cancer in the teen population. She received a standing ovation.

The meeting adjourned at 11:52 am.

Louis M Pate Jr.
Senator Pate, Presiding Chair

Edna Pearce
Edna Pearce, Committee Clerk

SENATE COMMITTEE ON HEALTH CARE
TUESDAY, May 12, 2015
11:00 A.M.
ROOM 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Introduction of Sergeants-at-Arms

BILLS:

BILL NO.	SHORT TITLE	SPONSOR
Pulled ~~HB 13~~	Amend School Health Assessment Requirement	Rep. Torbett
HB 195	Allow Substitution of Biosimilars	Rep. Dollar Rep. S. Martin Rep. Avila Rep. Lambeth
HB 437	Create Permit Exemptions/Home Renal Products	Rep. Dobson
HB 158	Jim Fulghum Teen Skin Cancer Prevention Act	Rep. Lambeth Rep. Dollar Rep. Hurley Rep. McElraft

ADJOURNMENT

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, May 12, 2015

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

FAVORABLE

HB **158** Jim Fulghum Teen Skin Cancer Prevention Act.
Draft Number: None
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

HB **195** **(CS#1)** Allow Substitution of Biosimilars.
Draft Number: None
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

HB **437** **(CS#1)** Create Permit Exemptions/Home Renal Products.
Draft Number: None
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Senator Tommy Tucker will handle HB 158
Senator Tom Apodaca will handle HB 195
Senator Ralph Hise will handle HB 437

HOUSE BILL 195:
Allow Substitution of Biosimilars

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	May 12, 2015
Introduced by:	Reps. Dollar, S. Martin, Avila, Lambeth	**Prepared by:**	Theresa Matula Kristen Harris Committee Counsel
Analysis of:	Second Edition		

SUMMARY: House Bill 195 would amend the NC Pharmacy Practice Act. The bill would provide definitions for biological and interchangeable products; allow for the substitution of an interchangeable biological product for a prescribed drug product; require communication between a pharmacist and prescriber under certain circumstances when a biological product is dispensed; and require the Board of Pharmacy to maintain a list of biological products determined by the FDA to be interchangeable with a specific biological product. The bill would extend the liability protection a pharmacist currently has for substituting a generic drug product for a prescribed drug product to the substitution of an interchangeable drug product for a prescribed drug product.

[As introduced, this bill was identical to S197, as introduced by Senators Apodaca and Hise which is currently in Senate Health Care.]

CURRENT LAW: The NC Pharmacy Practice Act allows a pharmacist to dispense an equivalent drug product (typically referred to as a generic) when a brand name drug is prescribed, provided that certain standards are met. Under 90-85.28, the prescriber may specify that an equivalent drug product is not to be used by utilizing one of three methods:

- By selecting on the prescription form whether product selection is permitted or whether the pharmacist must dispense as written.
- Notating "dispense as written" on the prescription.
- When ordering a prescription orally, specifying that the product be dispensed as written or allowing for product selection.

With regard to refills, a narrow therapeutic index drug (a drug having a narrowly defined range between risk and benefit) must be refilled using the same drug product by the same manufacturer that the pharmacist last dispensed, unless the pharmacist notifies the prescriber prior to dispensing another manufacturer's product and the patient consents.

Pharmacists are not allowed to select an equivalent drug product unless its cost to the purchaser is less than the price of the prescribed drug.

BACKGROUND:

The Patient Protection and Affordable Care Act (ACA) created an abbreviated licensure pathway for biological products that are demonstrated to be "biosimilar" to or "interchangeable" with an FDA-approved biological product. A "biosimilar" is a biological product that is highly similar to a U.S.-licensed reference biological product notwithstanding minor differences in the clinically inactive components, and for which there are no clinically meaningful differences between the biological product and the reference product in terms of safety, purity, and potency of the product. A healthcare provider

has to write the specific name of the biosimilar on the prescription to prescribe it. An interchangeable biological product is biosimilar to an FDA-approved reference product and can be expected to produce the same clinical result and may be substituted without the intervention of a healthcare provider who prescribed the reference product.[1] The first biosimilar was approved on March 6, 2015.[2] At this time, there are no approved interchangeable biological products.

BILL ANALYSIS:

Section 1 would add the terms biological product and interchangeable biological product to the definitions found in G.S. 90-85.27 which is part of the North Carolina Pharmacy Practice Act. Both definitions reference those found in the federal regulations under 42 USC 262.

Section 2 would make conforming changes to allow for interchangeable biological products to be treated the same as equivalent drug products when a pharmacist is making a substitution. **Section 2** would also add these new subsections to G.S. 90-85.28.

- Subsection (b2) would require a pharmacist or a designee to communicate to the prescriber of a biological product the name and manufacturer of the product dispensed to the patient. The communication would have to be done by making an entry into one of the following: 1) an interoperable electronic medical records system, 2) an electronic prescribing technology, 3) a pharmacy benefit management system, or 4) or pharmacy record that could be electronically accessed by the provider. If no such communication method is available, then the pharmacist or designee has to provide the product name and manufacturer by fax, phone, email or other means, except no communication is required if there was no FDA-approved interchangeable biological product for the product prescribed or the refill prescription was not changed from the product dispensed on the prior filling of the prescription.
- Subsection (b3) would require the North Carolina Board of Pharmacy to maintain a link on its website to the current list of biological products determined by the FDA to be interchangeable with a specific biological product.
- Subsection (b4) would direct that if the State mandates electronic medical records between a pharmacist and a prescriber as described in subsection (b2), then the pharmacist would only be required to communicate the biological product dispensed through an electronic medical records system when such a system is in place and the information is accessible by the prescriber.

Section 3 would amend G.S. 90-85.31 by extending the protections from liability that a pharmacist or prescriber has when selecting an equivalent drug product to the selection of an interchangeable biological product. The selection of an equivalent drug product or an interchangeable drug product would not impose a greater liability upon the pharmacist or the prescriber than if they had dispensed the drug product specified in the prescription.

Section 4 would make a technical change to conform to changes made to the definitions in **Section 1** of the bill.

EFFECTIVE DATE: This act becomes effective October 1, 2015. G.S. 90-85.28(b2) and G.S. 90-85.28(b4) as enacted by Section 2 of this act expire on October 1, 2020.

Amy Jo Johnson, former Committee Counsel to Senate Health Care, substantially contributed to this summary.

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[1] http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm241718.htm

[2] Zarxio is used to prevent infections in cancer patients receiving chemotherapy.

HOUSE BILL 195*
Committee Substitute Favorable 4/1/15

Short Title: Allow Substitution of Biosimilars. (Public)

Sponsors:

Referred to:

March 11, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA PHARMACY PRACTICE ACT TO ALLOW FOR THE SUBSTITUTION OF AN INTERCHANGEABLE BIOLOGICAL PRODUCT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.27 reads as rewritten:

"**§ 90-85.27. Definitions.**

As used in G.S. 90-85.28 through G.S. 90-85.31:

(1) Biological product. – As defined in section 351(i) of the Public Health Service Act, 42 U.S.C. § 262(i).

(1a) ~~"Equivalent drug product" means a~~Equivalent drug product. – A drug product which has the same established name, active ingredient, strength, quantity, and dosage form, and which is therapeutically equivalent to the drug product identified in the ~~prescription:~~prescription.

(2) ~~"Established name" has the meaning given~~Established name. – As defined in section 502(e)(3) of the Federal Food, Drug and Cosmetic Act, ~~21 U.S.C. 352(e)(3):~~21 U.S.C. § 352(e)(3).

(3) ~~"Good manufacturing practice" has the meaning given it~~Good manufacturing practice. – As defined in Part 211 of Chapter 1 of Title 21 of the Code of Federal ~~Regulations;~~Regulations.

(3a) Interchangeable biological product. – A biological product determined by the United States Food and Drug Administration to meet the standards set forth in 42 U.S.C. § 262(k)(4), or deemed therapeutically equivalent by the United States Food and Drug Administration.

(4) ~~"Manufacturer" means the~~Manufacturer. – The actual manufacturer of the finished dosage form of the ~~drug;~~drug.

(4a) ~~"Narrow therapeutic index drugs" means those~~Narrow therapeutic index drugs. – Those pharmaceuticals having a narrowly defined range between risk and benefit. Such drugs have less than a twofold difference in the minimum toxic concentration and minimum effective concentration in the blood or are those drug product formulations that exhibit limited or erratic absorption, formulation-dependent bioavailability, and wide intrapatient pharmacokinetic variability that requires blood-level monitoring. Drugs identified as having narrow therapeutic indices shall be designated by the North Carolina Secretary of Health and Human Services upon the advice of the State Health Director, North Carolina Board of Pharmacy, and North

Carolina Medical Board, as narrow therapeutic index drugs and shall be subject to the provisions of G.S. 90-85.28(b1). The North Carolina Board of Pharmacy shall submit the list of narrow therapeutic index drugs to the Codifier of Rules, in a timely fashion for publication in January of each year in the North Carolina Register.

(5) ~~"Prescriber" means anyone~~Prescriber. – Anyone authorized to prescribe drugs pursuant to the laws of this State."

SECTION 2. G.S. 90-85.28 reads as rewritten:

"**§ 90-85.28. Selection by pharmacists permissible; prescriber may permit or prohibit selection; price limit on selected ~~drugs.~~drugs; communication of dispensed biological products under specified circumstances.**

(a) A pharmacist dispensing a prescription for a drug product prescribed by its brand name may select any equivalent drug or interchangeable biological product which meets all of the following standards:

(1) The manufacturer's name and the distributor's name, if different from the manufacturer's name, shall appear on the label of the stock ~~package;~~package.

(2) It shall be manufactured in accordance with current good manufacturing ~~practices;~~practices.

(3) ~~Effective January 1, 1982, all~~All oral solid dosage forms shall have a logo, or other identification mark, or the product name to identify the manufacturer or ~~distributor;~~distributor.

(4) The manufacturer shall have adequate provisions for drug ~~recall; and~~recall.

(5) The manufacturer shall have adequate provisions for return of outdated drugs, through ~~his~~ the distributor or otherwise.

(b) The pharmacist shall not select an equivalent drug or interchangeable biological product if the prescriber instructs otherwise by one of the following methods:

(1) A prescription form shall be preprinted or stamped with two signature lines at the bottom of the form which read:

"_____ _____

Product Selection Permitted Dispense as Written"

On this form, the prescriber shall communicate ~~his~~ instructions to the pharmacist by signing the appropriate line.

(2) In the event the preprinted or stamped prescription form specified in ~~(b)(1)~~ subdivision (1) of subsection (b) of this section is not readily available, the prescriber may handwrite "Dispense as Written" or words or abbreviations of the same meaning on a prescription form.

(3) When ordering a prescription orally, the prescriber shall specify either that the prescribed drug product be dispensed as written or that product selection is permitted. The pharmacist shall note the instructions on the file copy of the prescription and retain the prescription form for the period prescribed by law.

(b1) A prescription for a narrow therapeutic index drug shall be refilled using only the same drug product by the same manufacturer that the pharmacist last dispensed under the prescription, unless the prescriber is notified by the pharmacist prior to the dispensing of another manufacturer's product, and the prescriber and the patient give documented consent to the dispensing of the other manufacturer's product. For purposes of this subsection, the term "refilled" shall include a new prescription written at the expiration of a prescription which continues the patient's therapy on a narrow therapeutic index drug.

(b2) Within a reasonable time following the dispensing of a biological product requiring a prescription, the pharmacist or a designee shall communicate to the prescriber the product name and manufacturer of the specific biological product dispensed to the patient. This

required communication shall be conveyed by making an entry into an interoperable electronic medical records system, or electronic prescribing technology, or a pharmacy benefit management system, or a pharmacy record that can be electronically accessible by the prescriber. Entry into one of the above referenced methods of communication is presumed to provide the required communication. Otherwise, the pharmacist or a designee shall provide the required communication to the prescriber by facsimile, telephone, electronic transmission, or other prevailing means, provided that communication shall not be required under any of the following circumstances:

(1) There is no United States Food and Drug Administration-approved interchangeable biological product for the product prescribed.

(2) A refill prescription is not changed from the product dispensed on the prior filling of the prescription.

(b3) The Board of Pharmacy shall maintain a link on its Internet Web site to the current list of biological products determined by the United States Food and Drug Administration to be interchangeable with a specific biological product.

(b4) If the State mandates electronic medical records between a pharmacist and a prescriber as described in subsection (b2) of this section, then the pharmacist shall only be required to communicate the biological product dispensed through an electronic medical records system when such a system is in place and the information is accessible by the prescriber.

(c) The pharmacist shall not select an equivalent drug or interchangeable biological product unless its price to the purchaser is less than the price of the prescribed drug product."

SECTION 3. G.S. 90-85.31 reads as rewritten:

"**§ 90-85.31. Prescriber and pharmacist liability not extended.**

The selection of an equivalent drug or interchangeable biological product pursuant to this Article shall impose no greater liability upon the pharmacist for selecting the dispensed drug or biological product or upon the prescriber of the same than would be incurred by either for dispensing the drug or biological product specified in the prescription."

SECTION 4. G.S. 58-3-178(c)(4) reads as rewritten:

"(4) "Prescribed contraceptive drugs or devices" means drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State. Prescription drugs or devices required to be covered under this section shall not include:

a. The prescription drug known as "RU-486" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27.

b. The prescription drug marketed under the name "Preven" or any "equivalent drug product" as defined in ~~G.S. 90-85.27(1).~~G.S. 90-85.27."

SECTION 5. This act becomes effective October 1, 2015. G.S. 90-85.28(b2) and G.S. 90-85.28(b4) as enacted by Section 2 of this act shall expire on October 1, 2020.

HOUSE BILL 158:
Jim Fulghum Teen Skin Cancer Prevention Act

2013-2014 General Assembly

Committee:	Senate Health Care	**Date:**	May 12, 2015
Introduced by:	Reps. Lambeth, Dollar, Hurley, McElraft	**Prepared by:**	Theresa Matula Kristen Harris Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 125 would require operators of tanning equipment to prohibit any person less than 18 years old from using the equipment.***

[As introduced, this bill was identical to S125, as introduced by Sens. Tucker, Meredith, Curtis, which is currently in Senate Health Care.]

CURRENT LAW: G.S. 104E-9.1(a)(2) prohibits operators of tanning equipment from allowing any person 13 years old or younger from using the equipment without a written prescription from the person's medical physician that specifies the nature of the medical condition requiring the treatment, the number of visits, and the amount of exposure time for each visit.

BILL ANALYSIS: Senate Bill 125 would amend G.S. 104E-9.1(a)(2) to require that operators of tanning equipment prohibit any person less than 18 years old from using the equipment.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H.B. 158
Mar 4, 2015
HOUSE PRINCIPAL CLERK

H **D**

HOUSE DRH20041-MG-26D* (01/28)

Short Title:	Jim Fulghum Teen Skin Cancer Prevention Act.	(Public)
Sponsors:	Representatives Lambeth, Dollar, Hurley, and McElraft (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT PROHIBITING PERSONS UNDER EIGHTEEN YEARS OF AGE FROM USING TANNING EQUIPMENT.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as the Jim Fulghum Teen Skin Cancer Prevention Act.

SECTION 2. G.S. 104E-9.1(a) reads as rewritten:

"(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person ~~13 years and younger~~under 18 years of age to use tanning ~~equipment without a written prescription from the person's medical physician specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.~~equipment.

(3) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits."

SECTION 3. This act becomes effective October 1, 2015.

HOUSE BILL 437:
Create Permit Exemptions/Home Renal Products

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	May 11, 2015
Introduced by:	Rep. Dobson	**Prepared by:**	Theresa Matula
Analysis of:	Second Edition		Committee Staff

SUMMARY: ***House Bill 437 amends the North Carolina Pharmacy Practice Act to create a pharmacy permit exemption for dispensing and delivery of dialysate or drugs necessary to perform home renal dialysis; to allow pharmacies to ship medications for home use by patients with renal failure to dialysis facilities; and to create an exemption from device and medical equipment permits for home renal products.***

[As introduced, this bill was identical to S557, as introduced by Sen. Hise, which is currently in Senate Health Care.]

CURRENT LAW:

G.S. 90-85.21 and G.S. 90-85.21A regulate pharmacy permits.

- Each pharmacy in North Carolina is required to annually register with the Board of Pharmacy (Board) and include specified information about its pharmacist-manager and all pharmacy personnel.
- Physicians who dispense prescription drugs must annually register with the Board and with the licensing board having jurisdiction over the physician.
- Out-of-state pharmacy operations which ship, mail, or deliver prescription drugs must also annually register with the Board. The out-of-state operations must certify that they employ a pharmacist who is responsible for dispensing, shipping, mailing, or delivering prescription drugs into this State or in a state approved by the Board and has met requirements for licensure equivalent to the requirements for licensure in North Carolina. The out-of-state pharmacist must agree in writing to be subject to the jurisdiction of the Board, the provisions of the Pharmacy Practice Act, and the rules adopted by the Board.

G.S. 90-85.22 pertains to medical devices and equipment and requires each location where devices are dispensed or delivered, or that deliver medical equipment, to a user in North Carolina to register annually with the Board, unless the business already has a current pharmacy permit.

G.S. 106-145.3 requires every wholesale distributor of prescription drugs in this State to obtain a license from the Department of Agriculture for each location from which prescription drugs are distributed and renew the license annually.

BILL ANALYSIS:

Section 1 of House Bill 437 adds a new section, G.S. 90-85.21C, to create a pharmacy permit exemption for any location or facility within or outside of North Carolina from which dialysate or drugs necessary to perform home renal dialysis are dispensed and delivered to a patient in North Carolina if all of the following criteria are met:

- The dialysate or drugs have been approved or cleared by the United States Food and Drug Administration.

- The dialysate or drugs are lawfully held by a manufacturer, or agent of the manufacturer, or wholesaler that is properly licensed in North Carolina.
- The dialysate or drugs are held, delivered, and dispensed in their original sealed packaging from the manufacturing facility.
- The dialysate or drugs are delivered only by the manufacturer or agent of a manufacturer and only upon receipt of a physician's order.
- The manufacturer or agent of the manufacturer delivers the dialysate drugs to either of the following:
    - A patient with chronic kidney failure or a designee of the patient, for self-administration of the dialysis therapy.
    - A health care provider or health care facility licensed under Chapter 122C, 131D, or 131E of the General Statutes, for administration or delivery of the dialysis therapy to a patient with chronic kidney failure.

Section 1 of the bill also creates G.S. 90-85.21D to allow pharmacies to ship medications for home use by patients with renal failure to dialysis facilities for delivery to: (i) patients receiving dialysis treatment in a Medicare certified dialysis facility, or (ii) the patient's home for self-dialysis. All of criteria below must be met before a pharmacy may mail medications to the renal dialysis facilities.

- The patient authorizes, in writing, the dialysis facility staff to act as the patient's designated agent for the purpose of receiving mailed medical packages at the dialysis facility.
- The pharmacy, whether in-state or out-of-state, is licensed as a pharmacy in North Carolina.
- The medications for home use are dispensed by the licensed pharmacist pursuant to a valid prescription order.
- The delivered medication packages are held in a secure location in an area not accessible to the public and delivered by the dialysis facility staff, unopened, to the patient.
- Medication packages are individually labeled with the patient name.
- The medications exclude controlled substances (as defined under G.S. 90 87).

Section 2 of the bill exempts the dispensing and delivery of home renal products from requiring a device and medical equipment permit under G.S. 90-85.22

EFFECTIVE DATE: This bill would become effective October 1, 2015.

Amy Jo Johnson, former staff to the House Health Committee contributed to this summary.

HOUSE BILL 437*
Committee Substitute Favorable 4/15/15

Short Title: Create Permit Exemptions/Home Renal Products. (Public)

Sponsors:

Referred to:

April 1, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE PHARMACY PRACTICE ACT TO CREATE A PHARMACY PERMIT EXEMPTION AND A DEVICE AND MEDICAL EQUIPMENT PERMIT EXEMPTION FOR THE DISPENSING AND DELIVERY OF HOME RENAL PRODUCTS AND TO ALLOW FOR DIALYSIS FACILITIES TO BE DESIGNATED AS AGENTS TO RECEIVE HOME MEDICATIONS FOR PATIENTS WITH RENAL FAILURE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 4A of Chapter 90 of the General Statutes is amended by adding two new sections to read:

"**§ 90-85.21C. Pharmacy permit exemption for dispensing and delivery of home renal products.**

Each location or facility within or outside this State from which dialysate or drugs necessary to perform home renal dialysis are dispensed and delivered to a patient in this State is exempt from the pharmacy permit requirements established by G.S. 90-85.21 and G.S. 90-8.21A, provided that all the following criteria are met:

(1) The dialysate or drugs have been approved or cleared by United States Food and Drug Administration.

(2) The dialysate or drugs are lawfully held by a manufacturer or an agent of the manufacturer that is properly licensed by the North Carolina Department of Agriculture and Consumer Services as a manufacturer, or as a wholesaler, or as both, as required by G.S. 106-145.3.

(3) The dialysate or drugs are held, delivered, and dispensed in their original, sealed packaging from the manufacturing facility.

(4) The dialysate or drugs are delivered only by the manufacturer, or an agent of the manufacturer, and only upon receipt of a physician's order.

(5) The manufacturer or an agent of the manufacturer delivers the dialysate or drugs directly to either of the following:

a. A patient with chronic kidney failure or a designee of the patient, for self-administration of the dialysis therapy.

b. A health care provider, or health care facility licensed under Chapter 122C, 131D, or 131E of the General Statutes, for administration or delivery of the dialysis therapy to a patient with chronic kidney failure.

"**§ 90-85.21D. Dialysis facilities as designated agents to receive home medications for patients with renal failure.**

Pharmacies may ship medications for home use by patients with renal failure to renal dialysis facilities for delivery to (i) patients who receive dialysis treatments in a Medicare certified dialysis facility or (ii) patients who self-dialyze at home, provided that all of the following criteria are met:

(1) The patient authorizes, in writing, the dialysis facility staff to act as the patient's designated agent for the purpose of receiving mailed medical packages at the dialysis facility.

(2) The pharmacy, whether in-state or out-of-state, is licensed as a pharmacy in North Carolina.

(3) The medications for home use are dispensed by the licensed pharmacist pursuant to a valid prescription order.

(4) The delivered medication packages are held in a secure location in an area not accessible to the public and delivered by the dialysis facility staff, unopened, to the patient.

(5) Medication packages are individually labeled with the patient name.

(6) The medications exclude controlled substances, as defined under G.S. 90-87."

SECTION 2. G.S. 90-85.22 reads as rewritten:

"**§ 90-85.22. Device and medical equipment ~~permits.~~permits; exemptions.**

...

(c) This section shall not apply to ~~either~~ any of the following:

(1) A pharmaceutical manufacturer registered with the Food and Drug Administration.

(2) A wholly owned subsidiary of a pharmaceutical manufacturer registered with the Food and Drug Administration.

(3) The dispensing and delivery of home renal products in accordance with the criteria specified in G.S. 90-85.21C."

SECTION 3. This act becomes effective October 1, 2015.

Senate Sgt at Arms

Sen Health 11:00 AM 5/12/2015

Donna Blake

~~**Canton Lewis**~~ HAL ROACH

Steve Wilson

SENATE PAGES ATTENDING

COMMITTEE: Health Care ROOM: 544

DATE: 5-12 TIME: 11 AM

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

Page Name	Hometown	Sponsoring Senator
1. Brandon Wallace	nashville	Angela Bryant
2. Deonte' mckenney	Fayetteville	Clark
3. Qy'Darrius mcEachern	Lumberton	Smith
4. Rachel Gore	Wilmington	Rabon
5. Elizabeth White	Deep Gap	Dan Soucek
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.

VISITOR REGISTRATION SHEET

SENATE HEALTH
(Committee Name)

5-12-15
Date

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Margaret Roberson	
Donna B Clarke	UNC Dept Govt
Valerie E. Glass	NCNA
Bobby Lowery, PhD, FNP	NCNA
Tom V, TAC Lobbyist	NC CHILD
Katherine Joyce	NCASA
Dodie Renfer	CCR
Ashley Perkins	Perkins Law
Annalicse Dolph	DL
Bruce Muldowney	NCSBA
Elizabeth Curlin	NCBON
Doris Hollocker	NC Board of Nursing
Jennifer Lewis	NC Board of Nursing
Amanda Hoover	TSD
Andy Chase	KMA
Burt Jenkins	NCDPI

VISITOR REGISTRATION SHEET

SENATE HEALTH
(Committee Name)

5-12-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Ryan Mirwald	UNC
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Kay Castillo	NASW-NC
NICHOLE KARAM	NAMI NC
Jennifer Mahan	ASNC
Joni Teague	NMRS
	hilly -
Michael Hauser	THCG
Rob Hamme	RLA
Diana H. Shaw MD	UNC Dean

VISITOR REGISTRATION SHEET

SENATE HEALTH
(Committee Name)

5-12-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Dana Simpson	SHA
Tim Boyce	Novartis
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Kara Weishaar	Smith Anderson
ANDY WALSH	SA
Hayden Robinson	NCRMA
Lexi Morgan	NCRMA
Joanna Spruill	NCAFP
Laurie Orrico	LALC
[illegible]	LALC
Lanier Hudgins	UNC Health Care

VISITOR REGISTRATION SHEET

SENATE HEALTH
(Committee Name)

5-12-15
Date

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Martha A. McConnell	Carolinas HealthCare Sys.
Erica Nelson	NCHA
Curtis McDonald	BMS
J Peters	CSS
Susan Harm	NCSSWA
Joyce Peters	CSS
[illegible]	[illegible]
John Hardin	MF&S
Mia Guglielmi	NC Metro Mayors
Michelle Frazier	MF&S
John McMillan	MF&S
Bill Scoggin	TS
Marty Bocock	Prime Therapeutics
[illegible]	NCMS
Cory Hanno	NCHA
Maggie [illegible]	GSR
Daniel Ball	Troutman Sanders
JJ Darby	J&J.

09-21-201

Chris Lowe — BCBSNC

Tan Riedman — ATP/DSS

Trent Womble — DHHS

Chris Hoke — DHHS-DPH

Gary Pendleton — N.C. House

VISITOR REGISTRATION SHEET

SENATE HEALTH
(Committee Name)

5-12-15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

Senate Committee on Health Care
Thursday, June 11, 2015 at 10:00 AM
544 Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 12, 2015, in Room 544 of the Legislative Office Building. Sixteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing a volunteer intern with Senator Pate's office, Anna Deuchle of Mecklenburg County; the pages—Savannah Bell and Joah Bickley of Rutherford County, Jazmine Boykins of Guilford County, Autumn Fulton of Snellville, Georgia, Andrew Grierson of Cumberland County, Cameron Rogers of Vance County, Fallon Stegall of Union County, Savannah Strickland of Wayne County, and Blake Wiseman of Wake County—and the Sergeants-at-Arms—Ed Kesler and Canton Lewis.

Senator Hise recognized Senator Daniel to present House Bill 467—Cleveland County Coroner/ME Recommendations. Senator Jim Davis moved for consideration of PCS for House Bill 467; the motion passed. Senator Daniel explained the PCS, along with Theresa Matula, Research Division, who explained the difference between the House Bill 467 and the PCS. Senator Daniel answered questions from Committee members. Senator Jim Davis and Senator McKissick moved for a favorable report to the PCS, unfavorable to the original PCS. The motion passed.

Senator Hise recognized Senator Tommy Tucker to present House Bill 766—Amend CBD Oil Statute. Senator Wade moved to consider the PCS before the Committee; the motion passed. Senator Tucker explained the PCS and answered questions from Committee members; a member of the public, Scott Lewis of Granville County, spoke in support of the PCS. Senator Bingham moved for a favorable report to the PCS, unfavorable to the original PCS. The motion passed.

Senator Hise recognized Representative Dobson to present House Bill 327—Study EMS Safety. Senator Wade moved for consideration of the PCS for the bill; the motion passed. Representative Dobson explained the bill and took questions from Committee members. Sen. Rabin moved for a favorable report to the PCS, unfavorable to the original bill. The motion passed.

Senator Hise recognized Representative Blackwell to present House Bill 652—Right to Try Act for Terminally Ill Patients. Representative Blackwell explained the bill and answered questions from Committee members. Senator McKissick moved for a favorable report. The motion passed.

The meeting adjourned at 10:55 AM.

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Senate Committee on Health Care
Thursday, June 11, 2015, 10:00 AM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 327	Study EMS Safety.	Representative Dobson
HB 467	Cleveland County Coroner/ME Recommendations.	Representative Hastings
HB 652	Right to Try Act for Terminally Ill Patients.	Representative Blackwell Representative Hager Representative Lambeth Representative Reives
HB 766	Amend CBD Oil Statute.	Representative McElraft Representative Avila Representative Carney

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

CORRECTED REPORT #1

Thursday, June 11, 2015

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

FAVORABLE

HB **652** **(CS#1)** Right to Try Act for Terminally Ill Patients.

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

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

HB **327** Study EMS Safety.

Draft Number:	H327-PCS30394-TA-10
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

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

HB **467** **(CS#1)** Cleveland County Coroner/ME Recommendations.

Draft Number:	H467-PCS40470-SH-48
Sequential Referral:	Judiciary I
Recommended Referral:	None
Long Title Amended:	No

HB **766** **(CS#1)** Amend CBD Oil Statute.

Draft Number:	H766-PCS20369-TU-21
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 4

Senator Ralph Hise will handle HB 652
Senator Ralph Hise will handle HB 327
Senator Warren Daniel will handle HB 467
Senator Tommy Tucker will handle HB 766

This Bill Analysis reflects the contents of the bill as it was presented in committee.

2015-2016 General Assembly

HOUSE BILL 467: Cleveland County Coroner/ME Recommendations

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Judiciary I	**Date:**	June 10, 2015
Introduced by:	Rep. Hastings	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to Second Edition H467-CSSH-48		

SUMMARY: House Bill 467 allows the elected Coroner of Cleveland County to appoint medical examiners in Cleveland County. The PCS amends who the Coroner may appoint.

[As introduced, this bill was identical to S266, as introduced by Sen. Daniel, which is currently in Senate Re-ref to Health Care. If fav, re-ref to Judiciary I.]

CURRENT LAW:

Under G.S. 130A-382, the Chief Medical Examiner has authority to appoint one or more county medical examiners in each county for three year terms. In appointing medical examiners, the Chief Medical Examiner is required to give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, coroners, or emergency medical technician paramedics.

BILL ANALYSIS:

House Bill 467 is a local bill that authorizes the Coroner in Cleveland County, rather than the Chief Medical Examiner, to appoint medical examiners in Cleveland County. The bill provides that the Coroner of Cleveland County must give preference to physicians when appointing medical examiners, but allows appointment of the following professionals: licensed physician assistants, nurse practitioners, nurses, coroners, assistant coroners, and emergency medical technician-paramedics. The PCS adds "assistant coroners" to the list of professionals that may be appointed but removes the option to appoint "individuals he or she otherwise deems qualified."

EFFECTIVE DATE:

The act would be effective when it becomes law.

Wendy Graf Ray, staff to the Committee on Rules, Calendar, and Operations of the House, substantially contributed to this summary.

O. Walker Reagan
Director

Research Division
(919) 733-2578

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 2

HOUSE BILL 467
Committee Substitute Favorable 4/22/15

Short Title: Cleveland County Coroner/ME Recommendations. (Local)

Sponsors:

Referred to:

April 2, 2015

A BILL TO BE ENTITLED

AN ACT EXPANDING THE CATEGORY OF INDIVIDUALS WHO MAY BE APPOINTED AS COUNTY MEDICAL EXAMINERS IN CLEVELAND COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding G.S. 130A-382, the duly elected Coroner of Cleveland County shall appoint the medical examiners in Cleveland County. The Coroner of Cleveland County shall give preference to physicians licensed to practice medicine in this State when appointing medical examiners, but may also appoint licensed physician assistants, nurse practitioners, nurses, coroners, emergency medical technician-paramedics, and individuals he or she otherwise deems qualified.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 467
Committee Substitute Favorable 4/22/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H467-CSSH-48 [v.3]

6/10/2015 5:19:07 PM

Short Title: Cleveland County Coroner/ME Recommendations. (Local)

Sponsors:

Referred to:

April 2, 2015

A BILL TO BE ENTITLED

AN ACT EXPANDING THE CATEGORY OF INDIVIDUALS WHO MAY BE APPOINTED AS COUNTY MEDICAL EXAMINERS IN CLEVELAND COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding G.S. 130A-382, the duly elected Coroner of Cleveland County shall appoint the medical examiners in Cleveland County. The Coroner of Cleveland County shall give preference to physicians licensed to practice medicine in this State when appointing medical examiners, but may also appoint licensed physician assistants, nurse practitioners, nurses, coroners, assistant coroners, and emergency medical technician-paramedics.

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

HOUSE BILL 766:
Amend CBD Oil Statute

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	June 11, 2015
Introduced by:	Reps. McElraft, Avila, Carney	**Prepared by:**	Theresa Matula Kristen Harris Committee Staff and Counsel
Analysis of:	PCS to Second Edition H766-CSTU-21		

SUMMARY: The Proposed Committee Substitute for House Bill 766 would amend the exemption for the use or possession of hemp extract and authorize certain neurologists to use hemp extract to treat intractable epilepsy without participating in a pilot study.

[The PCS adds Sections 8 and 9 to the bill.]

CURRENT LAW AND BACKGROUND:

The North Carolina Epilepsy Alternative Treatment Act (NCEATA) was enacted into law by S.L. 2014-53 in 2014. NCEATA defines "intractable epilepsy" as a seizure disorder that, as determined by a neurologist, does not respond to three or more treatment options overseen by the neurologist.

The North Carolina Controlled Substances Act establishes criminal penalties for the use and possession of cannabis as a Schedule VI drug. Possession or use of cannabis is punishable as a Class 3 misdemeanor or higher.

Possession of cannabis in the form of a hemp extract used solely to treat intractable epilepsy is also punishable as a Class 3 misdemeanor or higher; however, an exemption to the Controlled Substances Act for certain uses or possession of hemp extract to treat intractable epilepsy was enacted by S.L. 2014-53, which will become effective upon the adoption of rules by the Department of Health and Human Services.

BILL ANALYSIS:

Section 1 would amend the law relating to an exemption for the use or possession of hemp extract by redefining the compositional characteristics of "hemp extract".

Section 2 would amend the purpose of NCEATA to permit medical professionals to treat intractable epilepsy with hemp extract, and to delete references to studies to be undertaken related to the use of hemp extract to treat intractable epilepsy.

Section 3 would amend NCEATA's definition of "neurologist" to include persons affiliated with the neurology department at one or more hospitals licensed in this State, and to delete the definition of pilot study.

Sections 4 through 7 would make conforming changes consistent with Section 3.

Section 8 would amend the effective date of S.L. 2014-53.

Section 9 would require the Department of Health and Human Services to establish and adopt rules to implement NCEATA.

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

O. Walker Reagan
Director

* H 7 6 6 - S M T U - 5 7 C S T U - 2 1 - V 6 *

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 766
Committee Substitute Favorable 4/22/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H766-CSTU-21 [v.2]

6/10/2015 6:07:49 PM

Short Title: Amend CBD Oil Statute. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE EXEMPTION FOR USE OR POSSESSION OF HEMP EXTRACT AND AUTHORIZING CERTAIN NEUROLOGISTS TO USE HEMP EXTRACT AS AN ALTERNATIVE TREATMENT FOR INTRACTABLE EPILEPSY WITHOUT PARTICIPATING IN A PILOT STUDY.

The General Assembly of North Carolina enacts:

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

"(a) As used in this section, "hemp extract" means an extract from a cannabis plant, or a mixture or preparation containing cannabis plant material, that has all of the following characteristics:

(1) Is composed of less than ~~three-tenths~~ five-tenths of one percent ~~(0.3%)~~ (0.5%) tetrahydrocannabinol by weight.

(2) Is composed of at least ~~ten~~ five percent ~~(10%)~~ (5%) cannabidiol by weight.

(3) Contains no other psychoactive substance."

SECTION 2. G.S. 90-113.100 reads as rewritten:

"**§ 90-113.100. Short title.**

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

(b) The purpose of this act is to permit medical professionals to ~~conduct limited-scope, evidence-based studies exploring the safety and efficacy of treating~~ treat intractable epilepsy using hemp extract.

(c) The General Assembly finds ~~the following:~~

~~(1)~~ ~~There~~ that there are children in this State suffering from intractable epilepsy for which currently available treatment options have been ineffective. Hemp extract shows promise in treating children with intractable epilepsy.

~~(2)~~ ~~Additional study of the use of hemp extract for the treatment of intractable epilepsy should be undertaken, and the medical research universities of the State of North Carolina are well-suited for this type of clinical exploration.~~"

SECTION 3. G.S. 90-113.101 reads as rewritten:

"**§ 90-113.101. Definitions.**

...

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

~~(1)~~ ~~The University of North Carolina at Chapel Hill.~~

~~(2)~~ ~~East Carolina University.~~

~~(3) Duke University.~~
~~(4) Wake Forest University.~~

(h) Patient. – A person who has been diagnosed by a neurologist with intractable epilepsy.

~~(i) Pilot Study. – An evidence-based investigation of the safety and efficacy of treating intractable epilepsy using hemp extract conducted by one or more neurologists registered pursuant to this Article.~~"

SECTION 4. G.S. 90-113.102 reads as rewritten:

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

(a) The Department shall create a secure, electronic, and online Intractable Epilepsy Alternative Treatment ~~Pilot Study~~ database registry for the registration of ~~pilot studies,~~ neurologists, caregivers, and patients as provided by this Article. The registry must be accessible to law enforcement agencies in order to verify registration of caregivers. The registry must prevent an active registration of a patient by multiple neurologists. At a minimum, the database shall consist of the following:

(1) The name and address of each registered ~~caregiver and the name of the pilot study the caregiver is associated with.~~caregiver.

(2) The name and address of each registered ~~patient and the name of the pilot study the patient is associated with.~~patient.

(3) The name, address, and qualifying ~~institutional~~ hospital affiliation of neurologists ~~conducting pilot studies~~ approving, recommending, or providing hemp extract as an alternative treatment for intractable epilepsy pursuant to this Article.

~~(4) The name, institutional affiliation, affiliated registered neurologists, and parameters of pilot studies.~~

(b) The Department shall contact the county department of health where the patient resides and provide the following information:

(1) The name and address of the registered caregiver.

(2) Identifying information contained on the caregiver registration card."

SECTION 5. G.S. 90-113.103 reads as rewritten:

"**§ 90-113.103. Registration of ~~pilot studies and~~ neurologists.**

(a) A neurologist seeking to ~~conduct a pilot study~~ approve, recommend, or provide hemp extract for one or more patients as an alternative treatment to intractable epilepsy pursuant to this Article shall submit an application to the Department providing all of the following information:

(1) The name of the ~~pilot study.~~neurologist.

(2) The ~~affiliated research institution.~~name of the hospital with which the neurologist is affiliated.

~~(3) The scientific and clinical parameters of the study.~~

(4) ~~The~~ An explanation of the treatment protocols established for approving, recommending, or providing hemp extract as an alternative treatment for intractable epilepsy to ensure patient safety.

~~(5) The name and address of the one or more neurologists associated with the pilot study.~~

(6) Any other information deemed necessary by the Department to ~~determine the safety and evidence-based nature of the pilot study.~~protect patient safety.

(b) The Department shall examine applications received pursuant to subsection (a) of this section and register in the database the ~~proposed pilot studies that~~ neurologists the Department ~~certifies follow minimal scientific methods and protect patient safety.~~certifies to

approve, recommend, or provide hemp extract for one or more patients as an alternative treatment for intractable epilepsy pursuant to this Article.

~~(c) The Department may monitor registered pilot studies to ensure continued adherence to patient safety protocols and the scientific parameters of the study.~~"

SECTION 6. G.S. 90-113.104 reads as rewritten:

"**§ 90-113.104. Caregiver registration card; application; fees.**

(a) The Department shall, in coordination with recommendations from the Department of Public Safety, establish the form and content of caregiver registration cards to be issued to individuals who satisfy the requirements set forth in this section.

(b) The Department shall issue a caregiver registration card, valid for a period of one year from issuance, to an individual who satisfies all of the following criteria:

(1) Is at least 18 years of age.

(2) Is a resident of North Carolina.

(3) Provides the Department with a statement signed by a neurologist ~~conducting a pilot study~~ that satisfies all of the following:

a. Demonstrates that a patient in the caregiver's care satisfies all of the following criteria:

1. Has been examined and is under the care of the neurologist.

2. Suffers from intractable epilepsy.

3. May benefit from treatment with hemp extract.

~~4. Is eligible for inclusion in the registered pilot study.~~

b. Contains a recommendation for the use of hemp extract for treatment of intractable ~~epilepsy as part of a registered pilot study.~~epilepsy.

c. Is consistent with records received from the neurologist, concerning the patient, contained in the database described in G.S. 90-113.102.

(4) Pays the Department a fee, not to exceed fifty dollars ($50.00), established by the Department under G.S. 90-113.106.

(5) Submits an application to the Department that contains all of the following:

a. The caregiver's name and address.

b. The patient's name and address.

c. A copy of the caregiver's valid government-issued photo identification.

d. Any additional information the Department finds necessary to implement this Article.

(c) The Department shall renew a caregiver registration card upon certification from the caregiver and the neurologist that all information initially provided to the Department under subsection (b) of this section is current or has been updated to reflect any changes. The Department shall charge a fee for renewal of a caregiver registration card, not to exceed twenty-five dollars ($25.00), established under G.S. 90-113.106."

SECTION 7. G.S. 90-113.105 reads as rewritten:

"**§ 90-113.105. Immunity for neurologists; medical records.**

(a) On a case-by-case basis, neurologists ~~conducting a registered pilot study~~ may approve of dispensation to a registered caregiver, as approved by this Article, hemp extract acquired from another jurisdiction.

(b) A neurologist shall not be subject to arrest or prosecution, penalized or disciplined in any manner, or denied any right or privilege for approving or recommending the use of hemp extract or providing a written statement or health records to the Department for the use of hemp extract pursuant to this Article.

(c) A neurologist ~~conducting a registered pilot study~~ who signs a statement as described in G.S. 90-113.104(b)(3) shall do the following:

(1) Keep a record of the evaluation and observation of a patient under the neurologist's care, including the patient's response to hemp extract treatment.

(2) Transmit the record described in subdivision (1) of this subsection to the Department upon request.

(d) All medical records received or maintained by the Department pursuant to this Article are confidential and may not be disclosed to the public. Nothing in this Article is intended to alter the provisions of G.S. 8-53 or G.S. 8-53.1."

SECTION 8. Section 5 of S.L. 2014-53 reads as rewritten:

"**SECTION 5.** ~~Section 3 of this act becomes effective upon adoption of rules pursuant to Section 4 of this act. The remainder of this~~ This act is effective when it becomes law."

SECTION 9. The Department of Health and Human Services shall establish and adopt rules to implement the provisions of this act.

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

HOUSE BILL 766
Committee Substitute Favorable 4/22/15

Short Title: Amend CBD Oil Statute. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT AMENDING THE EXEMPTION FOR USE OR POSSESSION OF HEMP EXTRACT AND AUTHORIZING CERTAIN NEUROLOGISTS TO USE HEMP EXTRACT AS AN ALTERNATIVE TREATMENT FOR INTRACTABLE EPILEPSY WITHOUT PARTICIPATING IN A PILOT STUDY.

The General Assembly of North Carolina enacts:

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

"(a) As used in this section, "hemp extract" means an extract from a cannabis plant, or a mixture or preparation containing cannabis plant material, that has all of the following characteristics:

(1) Is composed of less than ~~three-tenths~~ five-tenths of one percent ~~(0.3%)~~ (0.5%) tetrahydrocannabinol by weight.

(2) Is composed of at least ~~ten~~ five percent ~~(10%)~~ (5%) cannabidiol by weight.

(3) Contains no other psychoactive substance."

SECTION 2. G.S. 90-113.100 reads as rewritten:

"**§ 90-113.100. Short title.**

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

(b) The purpose of this act is to permit medical professionals to ~~conduct limited-scope, evidence-based studies exploring the safety and efficacy of treating~~ treat intractable epilepsy using hemp extract.

(c) The General Assembly finds ~~the following:~~

~~(1)~~ ~~There~~ that there are children in this State suffering from intractable epilepsy for which currently available treatment options have been ineffective. Hemp extract shows promise in treating children with intractable epilepsy.

~~(2)~~ ~~Additional study of the use of hemp extract for the treatment of intractable epilepsy should be undertaken, and the medical research universities of the State of North Carolina are well-suited for this type of clinical exploration.~~"

SECTION 3. G.S. 90-113.101 reads as rewritten:

"**§ 90-113.101. Definitions.**

...

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

~~(1)~~ ~~The University of North Carolina at Chapel Hill.~~

~~(2)~~ ~~East Carolina University.~~

~~(3)~~ ~~Duke University.~~

~~(4) Wake Forest University.~~

(h) Patient. – A person who has been diagnosed by a neurologist with intractable epilepsy.

~~(i) Pilot Study. – An evidence-based investigation of the safety and efficacy of treating intractable epilepsy using hemp extract conducted by one or more neurologists registered pursuant to this Article.~~"

SECTION 4. G.S. 90-113.102 reads as rewritten:

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

(a) The Department shall create a secure, electronic, and online Intractable Epilepsy Alternative Treatment ~~Pilot Study~~ database registry for the registration of ~~pilot studies,~~ neurologists, caregivers, and patients as provided by this Article. The registry must be accessible to law enforcement agencies in order to verify registration of caregivers. The registry must prevent an active registration of a patient by multiple neurologists. At a minimum, the database shall consist of the following:

(1) The name and address of each registered ~~caregiver and the name of the pilot study the caregiver is associated with.~~caregiver.

(2) The name and address of each registered ~~patient and the name of the pilot study the patient is associated with.~~patient.

(3) The name, address, and qualifying ~~institutional~~ hospital affiliation of neurologists ~~conducting pilot studies~~ approving, recommending, or providing hemp extract as an alternative treatment for intractable epilepsy pursuant to this Article.

~~(4) The name, institutional affiliation, affiliated registered neurologists, and parameters of pilot studies.~~

(b) The Department shall contact the county department of health where the patient resides and provide the following information:

(1) The name and address of the registered caregiver.

(2) Identifying information contained on the caregiver registration card."

SECTION 5. G.S. 90-113.103 reads as rewritten:

"**§ 90-113.103. Registration of ~~pilot studies and~~ neurologists.**

(a) A neurologist seeking to ~~conduct a pilot study~~ approve, recommend, or provide hemp extract for one or more patients as an alternative treatment to intractable epilepsy pursuant to this Article shall submit an application to the Department providing all of the following information:

(1) The name of the ~~pilot study.~~neurologist.

(2) The ~~affiliated research institution.~~name of the hospital with which the neurologist is affiliated.

~~(3) The scientific and clinical parameters of the study.~~

(4) ~~The~~ An explanation of the treatment protocols established for approving, recommending, or providing hemp extract as an alternative treatment for intractable epilepsy to ensure patient safety.

~~(5) The name and address of the one or more neurologists associated with the pilot study.~~

(6) Any other information deemed necessary by the Department to ~~determine the safety and evidence-based nature of the pilot study.~~protect patient safety.

(b) The Department shall examine applications received pursuant to subsection (a) of this section and register in the database the ~~proposed pilot studies that~~ neurologists the Department ~~certifies follow minimal scientific methods and protect patient safety.~~certifies to approve, recommend, or provide hemp extract for one or more patients as an alternative treatment for intractable epilepsy pursuant to this Article.

~~(c) The Department may monitor registered pilot studies to ensure continued adherence to patient safety protocols and the scientific parameters of the study.~~"

SECTION 6. G.S. 90-113.104 reads as rewritten:

"**§ 90-113.104. Caregiver registration card; application; fees.**

(a) The Department shall, in coordination with recommendations from the Department of Public Safety, establish the form and content of caregiver registration cards to be issued to individuals who satisfy the requirements set forth in this section.

(b) The Department shall issue a caregiver registration card, valid for a period of one year from issuance, to an individual who satisfies all of the following criteria:

(1) Is at least 18 years of age.

(2) Is a resident of North Carolina.

(3) Provides the Department with a statement signed by a neurologist ~~conducting a pilot study~~ that satisfies all of the following:

a. Demonstrates that a patient in the caregiver's care satisfies all of the following criteria:

1. Has been examined and is under the care of the neurologist.

2. Suffers from intractable epilepsy.

3. May benefit from treatment with hemp extract.

~~4. Is eligible for inclusion in the registered pilot study.~~

b. Contains a recommendation for the use of hemp extract for treatment of intractable ~~epilepsy as part of a registered pilot study.~~epilepsy.

c. Is consistent with records received from the neurologist, concerning the patient, contained in the database described in G.S. 90-113.102.

(4) Pays the Department a fee, not to exceed fifty dollars ($50.00), established by the Department under G.S. 90-113.106.

(5) Submits an application to the Department that contains all of the following:

a. The caregiver's name and address.

b. The patient's name and address.

c. A copy of the caregiver's valid government-issued photo identification.

d. Any additional information the Department finds necessary to implement this Article.

(c) The Department shall renew a caregiver registration card upon certification from the caregiver and the neurologist that all information initially provided to the Department under subsection (b) of this section is current or has been updated to reflect any changes. The Department shall charge a fee for renewal of a caregiver registration card, not to exceed twenty-five dollars ($25.00), established under G.S. 90-113.106."

SECTION 7. G.S. 90-113.105 reads as rewritten:

"**§ 90-113.105. Immunity for neurologists; medical records.**

(a) On a case-by-case basis, neurologists ~~conducting a registered pilot study~~ may approve of dispensation to a registered caregiver, as approved by this Article, hemp extract acquired from another jurisdiction.

(b) A neurologist shall not be subject to arrest or prosecution, penalized or disciplined in any manner, or denied any right or privilege for approving or recommending the use of hemp extract or providing a written statement or health records to the Department for the use of hemp extract pursuant to this Article.

(c) A neurologist ~~conducting a registered pilot study~~ who signs a statement as described in G.S. 90-113.104(b)(3) shall do the following:

(1) Keep a record of the evaluation and observation of a patient under the neurologist's care, including the patient's response to hemp extract treatment.

(2) Transmit the record described in subdivision (1) of this subsection to the Department upon request.

(d) All medical records received or maintained by the Department pursuant to this Article are confidential and may not be disclosed to the public. Nothing in this Article is intended to alter the provisions of G.S. 8-53 or G.S. 8-53.1."

SECTION 8. This act is effective when it becomes law.

HOUSE BILL 327: Study EMS Safety/EMS Personnel Tech Changes.

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	June 11, 2015
Introduced by:	Rep. Dobson	**Prepared by:**	Jennifer Mundt Committee Staff
Analysis of:	PCS to Second Edition H327-CSTA-10 [v.2]		

SUMMARY: ***The Proposed Committee Substitute (PCS) for House Bill 327 would (i) direct an interagency study of how emergency medical service personnel can reduce the threat of bodily harm to them when performing duties necessary for the health and safety of the public and (ii) make technical and conforming changes to the statutes governing the regulation of emergency medical personnel services to reflect new national standards.***

BILL ANALYSIS: The PCS for House Bill 327 would:

Sections 1 and 2 would direct the Division of Health Service Regulation (Division) in the Department of Health and Human Services, in consultation with the North Carolina Medical Care Commission (Commission), and the Division of Emergency Management in the Department of Public Safety to study how emergency medical service (EMS) personnel can reduce the threat of bodily harm to them when performing duties for the health and safety of the public. The study must address:

- Crisis intervention courses.
- Self-defense tactics.
- Use of protective body garments and vests.
- Non-lethal deterrents such as conducted electrical weapons, chemical irritants, mace, pepper spray, and tear gas.

The Division must report its findings to the Joint Legislative Oversight Committee on Health and Human Services by April 1, 2016.

Sections 3 through 6 would make technical and conforming changes to the name of certain EMS personnel in Article 7 of Chapter 131E of the General Statutes (Regulation of Emergency Medical Services) to reflect and conform to EMS personnel licensure levels in the National Emergency Medical Personnel Education Standards of the National Highway Transportation Safety Administration.

Section 7 would direct the Commission to amend its applicable rules consistent with the changes in the act by December 31, 2015.

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

O. Walker Reagan
Director

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Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 327
Second Edition Engrossed 4/20/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H327-CSTA-10 [v.2]

6/10/2015 5:04:17 PM

Short Title: Study EMS Safety/EMS Personnel Tech Changes. (Public)

Sponsors:

Referred to:

March 24, 2015

A BILL TO BE ENTITLED

AN ACT TO (1) STUDY EMERGENCY MEDICAL SERVICE PERSONNEL SAFETY FROM HOSTILE THREATS AND WHAT DEFENSIVE RESOURCES SHOULD BE ALLOWED TO PREVENT INJURY TO THE EMERGENCY MEDICAL SERVICE PERSONNEL OR THE PATIENTS UNDER THEIR CARE AND (2) MAKE TECHNICAL AND CONFORMING CHANGES TO THE STATUTES GOVERNING THE REGULATION OF EMERGENCY MEDICAL SERVICES TO REFLECT NEW NATIONAL STANDARDS FOR EMERGENCY MEDICAL PERSONNEL.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Health Service Regulation, in consultation with the North Carolina Medical Care Commission and the Department of Public Safety, Division of Emergency Management, shall study how emergency medical service personnel can reduce the threat of bodily harm to them when performing duties necessary for the health and safety of the public. The study shall address all of the following:

(1) Crisis intervention courses.
(2) Self-defense tactics.
(3) Use of protective body garments and vests.
(4) Non-lethal deterrents such as conducted electrical weapons.
(5) Non-lethal deterrents such as chemical irritants, mace, pepper spray, and tear gas.

SECTION 2. The Division shall report its findings to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2016.

SECTION 3. G.S. 131E-155 reads as rewritten:

"**§ 131E-155. Definitions.**

As used in this Article, unless otherwise specified:

(1) "Ambulance" means any privately or publicly owned motor vehicle, aircraft, or vessel that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated for the transportation of patients on the streets or highways, waterways or airways of this State.
(2) Repealed by Session Laws 1997-443, s. 11A.129C.
(3) Redesignated as subdivision (13a).
(4) "Commission" means the North Carolina Medical Care Commission.
(5) "Emergency medical dispatcher" means an emergency telecommunicator who has completed an educational program approved by the Department and

has been credentialed as an emergency medical dispatcher by the Department.

(6) "Emergency medical services" means services rendered by emergency medical services personnel in responding to improve the health and wellness of the community and to address the individual's need for emergency medical care within the scope of practice as defined by the North Carolina Medical Board in accordance with G.S. 143-514 in order to prevent loss of life or further aggravation of physiological or psychological illness or injury.

(6a) "Emergency medical services instructor" means an individual who has completed educational requirements approved by the Department and has been credentialed as an emergency medical services instructor by the Department.

(6b) "Emergency Medical Services Peer Review Committee" means a panel composed of EMS program representatives to be responsible for analyzing patient care data and outcome measures to evaluate the ongoing quality of patient care, system performance, and medical direction within the EMS system. The committee membership shall include physicians, nurses, EMS personnel, medical facility personnel, and county government officials. Review of medical records by the EMS Peer Review Committee is confidential and protected under G.S. 143-518. An EMS Peer Review Committee, its members, proceedings, records and materials produced, and materials considered shall be afforded the same protections afforded Medical Review Committees, their members, proceedings, records, and materials under G.S. 131E-95.

(7) "Emergency medical services personnel" means all the personnel defined in subdivisions (5), (6a), (8), (9), (10), (12), (13), (14), and (15) of this section.

(8) "Emergency medical services-nurse practitioner" means a registered nurse who is licensed to practice nursing in North Carolina and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing. Upon successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, emergency medical services-nurse practitioners shall be approved by the medical director to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.

(9) "Emergency medical services-physician assistant" means a physician assistant who is licensed by the North Carolina Medical Board. Upon successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, emergency medical services-physician assistants shall be approved by the medical director to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.

(10) "Emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician by the Department.

(11) Repealed by Session Laws 2003-392, s. 2(a), effective August 7, 2003.

(12) ~~"Emergency medical technician intermediate"~~"Advanced emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an ~~emergency medical technician intermediate~~ advanced emergency medical technician by the Department.

(13) ~~"Emergency medical technician paramedic"~~"Paramedic" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed ~~as an emergency medical technician paramedic~~ a paramedic by the Department.

(13a) "EMS provider" means a firm, corporation or association which engages in or professes to provide emergency medical services.

(14) ~~"Medical responder"~~"Emergency medical responder" means an individual who has completed an educational program in emergency medical care and first aid approved by the Department and has been credentialed as ~~a~~ an emergency medical responder by the Department.

(15) "Mobile intensive care nurse" means a registered nurse who is licensed to practice nursing in North Carolina and is approved by the medical director, following successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.

(16) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless such that the need for some medical assistance might be anticipated.

(17) "Practical examination" means a test where an applicant for credentialing as an emergency medical technician, emergency medical responder, ~~emergency medical technician intermediate, or emergency medical technician paramedic~~advanced emergency medical technician, or paramedic demonstrates the ability to perform specified emergency medical care skills."

SECTION 4. G.S. 131E-153 reads as rewritten:

"**§ 131E-158. Credentialed personnel required.**

(a) Every ambulance when transporting a patient shall be occupied at a minimum by all of the following:

(1) At least one emergency medical technician who shall be responsible for the medical aspects of the mission prior to arrival at the medical facility, assuming no other individual with higher credentials is available.

(2) One emergency medical responder who is responsible for the operation of the vehicle and rendering assistance to the emergency medical technician.

An ambulance owned and operated by a licensed health care facility that is used solely to transport sick or infirm patients with known nonemergency medical conditions between facilities or between a residence and a facility for scheduled medical appointments is exempt from the requirements of this subsection.

(b) The Commission shall adopt rules setting forth exemptions to the requirements stated in (a) of this section applicable to situations where exemptions are considered by the Commission to be in the public interest."

SECTION 5. G.S. 131E-159 reads as rewritten:

"**§ 131E-159. Credentialing requirements.**

(a) Individuals seeking credentials as an emergency medical technician, ~~emergency medical technician intermediate, emergency medical technician paramedic,~~ advanced emergency medical technician, paramedic, emergency medical responder, emergency medical

dispatcher, or emergency medical services instructor shall apply to the Department using forms prescribed by that agency. The Department's representatives shall examine the applicant by either written, practical, or written and practical examination. The Department shall issue appropriate credentials to the applicant who meets all the requirements set forth in this Article and the rules adopted for this Article and who successfully completes the examinations required for credentialing. Emergency medical technician, emergency medical responder, emergency medical dispatcher, ~~emergency medical technician-intermediate, emergency medical technician-paramedic~~advanced emergency medical technician, paramedic, and emergency medical services instructor credentials shall be valid for a period not to exceed four years and may be renewed if the holder meets the requirements set forth in the rules of the Commission. The Department is authorized to revoke or suspend these credentials at any time it determines that the holder no longer meets the qualifications prescribed.

(b) The Commission shall adopt rules setting forth the qualifications required for credentialing of emergency medical responders, emergency medical technicians, ~~emergency medical technician-intermediates, emergency medical technician-paramedics,~~ advanced emergency medical technicians, paramedics, emergency medical dispatchers, and emergency medical services instructors.

(c) Individuals currently credentialed as an emergency medical technician, ~~emergency medical technician-intermediate, emergency medical technician-paramedic,~~ advanced emergency medical technician, paramedic, emergency medical responder, and emergency medical services instructor by the National Registry of Emergency Medical Technicians or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules promulgated by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with a permitted EMS provider offering service within North Carolina, may be eligible for credentialing as an emergency medical technician, ~~emergency medical technician-intermediate, emergency medical technician-paramedic,~~advanced emergency medical technical, paramedic, emergency medical responder, and emergency medical services instructor without examination. This credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

...

(f) The Department may deny, suspend, amend, or revoke the credentials of ~~a~~ an emergency medical responder, emergency medical technician, ~~emergency medical technician-intermediate, emergency medical technician-paramedic,~~ advanced emergency medical technician, paramedic, emergency medical dispatcher, or emergency medical services instructor in any case in which the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules issued under this Article. Prior to implementation of any of the above disciplinary actions, the Department shall consider the recommendations of the EMS Disciplinary Committee pursuant to G.S. 143-519. The Department's decision to deny, suspend, amend, or revoke credentials may be appealed by the applicant or credentialed personnel pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

...."

SECTION 6. G.S 14-276.1 reads as rewritten:

"**§ 14-276.1. Impersonation of firemen or emergency medical services personnel.**

It is a Class 3 misdemeanor, for any person, with intent to deceive, to impersonate a fireman or any emergency medical services personnel, whether paid or voluntary, by a false statement, display of insignia, emblem, or other identification on his person or property, or any other act, which indicates a false status of affiliation, membership, or level of training or proficiency, if:

(1) The impersonation is made with intent to impede the performance of the duties of a fireman or any emergency medical services personnel, or

(2) Any person reasonably relies on the impersonation and as a result suffers injury to person or property.

For purposes of this section, emergency medical services personnel means ~~a~~ an emergency medical responder, emergency medical technician, ~~emergency medical technician intermediates, emergency medical technician paramedics,~~ advanced emergency medical technician, paramedic, or other member of a rescue squad or other emergency medical organization."

SECTION 7. The North Carolina Medical Care Commission shall amend its applicable rules consistent with Sections 3 through 5 of this act no later than December 31, 2015.

SECTION 8. This act is effective when it becomes law.

HOUSE BILL 327
Second Edition Engrossed 4/20/15

Short Title:	Study EMS Safety.	(Public)
Sponsors:	Representative Dobson (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Judiciary II.	

March 24, 2015

A BILL TO BE ENTITLED

AN ACT TO STUDY EMERGENCY MEDICAL SERVICE PERSONNEL SAFETY FROM HOSTILE THREATS AND WHAT DEFENSIVE RESOURCES SHOULD BE ALLOWED TO PREVENT INJURY TO THE EMERGENCY MEDICAL SERVICE PERSONNEL OR THE PATIENTS UNDER THEIR CARE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Health Service Regulation, in consultation with the North Carolina Medical Care Commission and the Department of Public Safety, Division of Emergency Management, shall study how emergency medical service personnel can reduce the threat of bodily harm when performing duties necessary for the health and safety of the public. The study shall address all of the following:

(1) Crisis intervention courses.
(2) Self-defense tactics.
(3) Use of protective body garments and vests.
(4) Non-lethal deterrents such as conducted electrical weapons.
(5) Non-lethal deterrents such as chemical irritants, mace, pepper spray, and tear gas.

SECTION 2. The Division shall report its findings to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2016.

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

HOUSE BILL 652:
Right to Try Act for Terminally Ill Patients

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	June 10, 2015
Introduced by:	Reps. Blackwell, Hager, Lambeth, Reives	**Prepared by:**	Tawanda Foster Committee Counsel
Analysis of:	Second Edition		

SUMMARY: House Bill 652 would establish a process by which eligible patients who are terminally ill could obtain access to investigational drugs, biological products, and devices so long as various requirements are met.

CURRENT LAW: Generally, non-US Food and Drug Administration (FDA) approved prescription drugs are not available for patient use. Patients may participate, if eligible, in FDA approved clinical trials. If a patient is not eligible for a clinical trial, the FDA has an expanded access program for unapproved drugs; however the patient must be approved to obtain access by the FDA.

BILL ANALYSIS:

House Bill 652 would allow the manufacturer of an investigational drug, biological product, or device to make available to an eligible patient that manufacturer's investigational drug, biological product, or device. The manufacturer may provide this investigational drug, biological product, or device with or without a cost to the patient. The phrase "investigational drug, biological product, or device" is defined as "a drug, biological product, or device that has successfully completed Phase I of a clinical trial but has not yet been approved for general use by the [FDA] and remains under investigation in a clinical trial approved by the [FDA]."

In order for a person to be eligible to receive the investigation drug, biological product, or device, the following criteria must be met:

- The person must have a progressive medical or surgical condition that (i) entails significant functional impairment, (ii) is not considered by a treating physician to be reversible even with the administration of available treatments approved by the FDA, and (iii) will soon result in death without life-sustaining procedures. This diagnosis of a terminal illness must be attested by a physician.
- The person must have, in consultation with the treating physician, considered all other treatment options currently approved by the FDA.
- The person must have received a recommendation by the treating physician for use of the investigational drug, biological product, or device.
- The person must have given written, informed consent to use of the investigational drug, biological product, or device.
- There must be documentation from the treating physician that the person meets all of the criteria above. This documentation must include an attestation from the treating physician that the treating physician was consulted in the creation of the required written, informed consent.

O. Walker Reagan
Director

H652-SMTV-46 E2 -V1

Research Division
(919) 733-2578

With regards to the required written informed consent, House Bill 652 would require that the informed consent must be a written document that is signed by an eligible patient; or if the patient is a minor, by a parent or legal guardian; or if the patient is incapacitated, by a designated health care agent pursuant to a health care power of attorney. The written informed consent must include the following:

- An explanation of the currently approved products and treatments for the eligible patient's terminal illness.
- An attestation that the eligible patient concurs with the treating physician in believing that all currently approved treatments are unlikely to prolong the eligible patient's life.
- Clear identification of the specific investigational drug, biological product, or device proposed for treatment of the eligible patient's terminal illness.
- A description of the potentially best and worst outcomes resulting from use of the investigational drug, biological product, or device to treat the eligible patient's terminal illness, along with a realistic description of the most likely outcome.
- A statement that eligibility for hospice care may be withdrawn if the eligible patient begins treatment of the terminal illness with an investigational drug, biological product, or device, and that hospice care may be reinstated if such treatment ends and the eligible patient meets hospice eligibility requirements.
- A statement that the eligible patient's health benefit plan or third party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless specifically required to do so by law or contract.
- A statement that the eligible patient understands that he or she is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the eligible patient's estate, unless a contract between the patient and the manufacturer of the drug, biological product, or device states otherwise.
- A statement that the eligible patient or, for an eligible patient who is a minor or lacks capacity to provide informed consent, that the parent or legal guardian consents to the use of the investigational drug, biological product, or device for treatment of the terminal condition.

House Bill 652 would also prohibit any liability to the heirs of the eligible patient for any outstanding debt related to the use of investigational drugs, biological products, or devices.

House Bill 652 also contains provisions that would prohibit certain punitive actions from being taken against health care providers based upon a recommendation to an eligible patient regarding investigational drugs, biological products, or devices. No official, employee, or agent of the State would be able to take action to block or attempt to block an eligible patient's access to investigational drugs, biological products, or devices.

Under House Bill 652, no private right of action would be able to be brought against a manufacturer of an investigational drug, biological product, or device, or against any other person or entity involved in the care of an eligible patient using an investigational drug, biological product, or device, for any harm caused to the eligible patient resulting from use of the investigational drug, biological product, or device as long as the manufacturer or other person or entity has made a good faith effort to comply with the provisions of the act and has exercised reasonable care in undertaking his or her actions.

EFFECTIVE DATE: This act becomes effective October 1, 2015.

HOUSE BILL 652
Committee Substitute Favorable 4/20/15

Short Title: Right to Try Act for Terminally Ill Patients. (Public)

Sponsors:

Referred to:

April 14, 2015

A BILL TO BE ENTITLED

AN ACT ESTABLISHING A RIGHT TO TRY ACT TO PROVIDE EXPANDED ACCESS TO INVESTIGATIONAL DRUGS, BIOLOGICAL PRODUCTS, AND DEVICES FOR PATIENTS DIAGNOSED WITH TERMINAL ILLNESS.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 23A.
"Right to Try Act.

"**§ 90-325. Short title; purpose.**

(a) This Article shall be known and may be cited as the Right to Try Act.

(b) The purpose of this Article is to authorize access to and use of experimental treatments for patients with a terminal illness; to establish conditions for use of experimental treatment; to prohibit sanctions of health care providers solely for recommending or providing experimental treatment; to clarify duties of a health insurer with regard to experimental treatment authorized under this Article; to prohibit certain actions by State officials, employees, and agents; and to restrict certain causes of action arising from experimental treatment.

"**§ 90-325.1. Definitions.**

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

(1) Eligible patient. – An individual who meets all of the following criteria:

a. Has a terminal illness, attested to by a treating physician.

b. Has, in consultation with a treating physician, considered all other treatment options currently approved by the United States Food and Drug Administration.

c. Has received a recommendation from the treating physician for use of an investigational drug, biological product, or device for treatment of the terminal illness.

d. Has given informed consent in writing to use of the investigational drug, biological product, or device for treatment of the terminal illness or, if the individual is a minor or is otherwise incapable of providing informed consent, the parent or legal guardian has given informed consent in writing to use of the investigational drug, biological product, or device.

e. Has documentation from the treating physician that the individual meets all of the criteria for this definition. This documentation shall include an attestation from the treating physician that the treating

physician was consulted in the creation of the written, informed consent required under this Article.

(2) Investigational drug, biological product, or device. – A drug, biological product, or device that has successfully completed Phase I of a clinical trial but has not yet been approved for general use by the United States Food and Drug Administration and remains under investigation in a clinical trial approved by the United States Food and Drug Administration.

(3) Terminal illness. – A progressive disease or medical or surgical condition that (i) entails significant functional impairment, (ii) is not considered by a treating physician to be reversible even with administration of available treatments approved by the United States Food and Drug Administration, and (iii) will soon result in death without life-sustaining procedures.

(4) Written, informed consent. – A written document that is signed by an eligible patient; or if the patient is a minor, by a parent or legal guardian; or if the patient is incapacitated, by a designated health care agent pursuant to a health care power of attorney, that at a minimum includes all of the following:

a. An explanation of the currently approved products and treatments for the eligible patient's terminal illness.

b. An attestation that the eligible patient concurs with the treating physician in believing that all currently approved treatments are unlikely to prolong the eligible patient's life.

c. Clear identification of the specific investigational drug, biological product, or device proposed for treatment of the eligible patient's terminal illness.

d. A description of the potentially best and worst outcomes resulting from use of the investigational drug, biological product, or device to treat the eligible patient's terminal illness, along with a realistic description of the most likely outcome. The description shall be based on the treating physician's knowledge of the proposed treatment in conjunction with an awareness of the eligible patient's terminal illness and shall include a statement acknowledging that new, unanticipated, different, or worse symptoms might result from, and that death could be hastened by, the proposed treatment.

e. A statement that eligibility for hospice care may be withdrawn if the eligible patient begins treatment of the terminal illness with an investigational drug, biological product, or device and that hospice care may be reinstated if such treatment ends and the eligible patient meets hospice eligibility requirements.

f. A statement that the eligible patient's health benefit plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless specifically required to do so by law or contract.

g. A statement that the eligible patient understands that he or she is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the eligible patient's estate, unless a contract between the patient and the manufacturer of the drug, biological product, or device states otherwise.

h. A statement that the eligible patient or, for an eligible patient who is a minor or lacks capacity to provide informed consent, that the parent or legal guardian consents to the use of the investigational drug, biological product, or device for treatment of the terminal condition.

"**§ 90-325.2. Authorized access to and use of investigational drugs, biological products, and devices.**

(a) A manufacturer of an investigational drug, biological product, or device may make available to an eligible patient, and an eligible patient may request, the manufacturer's investigational drug, biological product, or device. However, nothing in this Article shall be construed to require a manufacturer of an investigational drug, biological product, or device to make such investigational drug, biological product, or device available to an eligible patient.

(b) A manufacturer of an investigational drug, biological product, or device may provide the investigational drug, biological product, or device to an eligible patient without receiving compensation or may require the eligible patient to pay the costs of, or the costs associated with, the manufacture of the investigational drug, biological product, or device.

"**§ 90-352.3. No liability to heirs for outstanding debt related to use of investigational drugs, biological products, or devices.**

If an eligible patient dies while being treated with an investigational drug, biological product, or device, the eligible patient's heirs are not liable for any outstanding debt related to the treatment, including any costs attributed to lack of insurance coverage for the treatment.

"**§ 90-325.4. Sanctions against health care providers prohibited.**

(a) A licensing board shall not revoke, fail to renew, suspend, or take any other disciplinary action against a health care provider licensed under this Chapter, based solely on the health care provider's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

(b) An entity responsible for Medicare certification shall not take action against a health care provider's Medicare certification based solely on the health care provider's recommendation that a patient have access to an investigational drug, biological product, or device.

"**§ 90-325.5. Prohibited conduct by State officials.**

No official, employee, or agent of this State shall block or attempt to block an eligible patient's access to an investigational drug, biological product, or device. Counseling, advice, or a recommendation consistent with medical standards of care from a licensed health care provider does not constitute a violation of this section.

"**§ 90-325.6. No private right of action against manufacturers of investigational drugs, biological products, or devices.**

No private right of action may be brought against a manufacturer of an investigational drug, biological product, or device, or against any other person or entity involved in the care of an eligible patient using an investigational drug, biological product, or device, for any harm caused to the eligible patient resulting from use of the investigational drug, biological product, or device as long as the manufacturer or other person or entity has made a good-faith effort to comply with the provisions of this Article and has exercised reasonable care in actions undertaken pursuant to this Article.

"**§ 90-325.7. Insurance coverage of clinical trials.**

Nothing in this Article shall be construed to affect a health benefit plan's obligation to provide coverage for an insured's participation in a clinical trial pursuant to G.S. 58-3-255."

SECTION 2. This act becomes effective October 1, 2015.

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 11, 2015

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
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J Peters	CSS
Judy Jenkins	Otsuka
David [illegible]	[illegible]
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Walden [illegible]	[illegible]
Alex Bowen	CCS
Peter Daniel	CCS
Lanier Hodgson	UNC Health Care
Erica Nelson	NCHA
Joanna Spruill	NCAFP
Jennifer [illegible]	NCMS
[illegible]	[illegible]
Gray Hand (T-WARE)	NCHA
Christine Craig	WakeMed
[illegible]	[illegible]
Fred Bone	Bone' Asso.

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 11, 2015

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Jessie Goodman	DHHS/DHSR
Sonya Brown	DMHDDSAS
Elizabeth Schab	NCPHA
Amanda Horaker	TSS
Andy Chase	RMA
Natalie Hobson	NCHFA
Will Parry-Hill	NCHFA
Butch Gunnells	NC Gov
[illegible]	DHHS
Steve Metcalf	Mission Health
Robert Jimm	Mission Health
Trent Womble	DHHS
Hugh Johnson	NCACC
Sarah Collins	NCLM
Kim Crouch	NCBA

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 11, 2015

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Courtney Johnson	Nexsen Pruet
Courtney Lockamy	Randolph Cloud + Assoc.
[illegible]	R. Cloud & Assoc.
John DelGrosso	Bickerton Assoc.
Michele Frazier	MFHS
Kara Weisbaar	SA

09-21-201

Senate Committee on Health Care
Tuesday, June 30, 2015 at 11:00 am
544 Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 11:00 am on June 30, 2015, in room 544 of the Legislative Office Building. Thirteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened by the meeting by welcoming everyone and recognizing the Senate Sergeant-at-Arms – Terry Barnhardt, Marcus Kitts and Dale Huff. Senator Hise also recognized the Senate Pages – Connor Brown of Pitt County (sponsored by Senator Pate), Lauren Hardin of Sampson County (sponsored by Senator Brent Jackson), Lillie Rhodes of Pitt County (sponsored by Senator Don Davis), Mary Allison Page of Guilford County (sponsored by Senator Krawiec), Abbey Rouse of Johnston County (sponsored by Senator Brent Jackson), Julia Vaughan-Jones of Davie County (sponsored by Senator Brock), Logan Jackson of Wake County (sponsored by Senator Blue), Blake Flinchum of Surry County (sponsored by Senator Randleman) and Allison Gallagher of Pitt County (sponsored by Senator Don Davis).

Senator Hise noted that SB 451 was removed from the calendar.

Senator Hise recognized Senator Robinson for a motion to consider a proposed committee substitute for HB 814. The motion passed unanimously by voice vote. Representative Riddell presented the bill. Senators Wade, Randleman, Don Davis, Robinson, Curtis and Tarte discussed the bill. Adam Sholar with the North Carolina Department of Health and Human Services also spoke regarding the bill. Senator Randleman moved for an unfavorable report as to the bill, but favorable report as to the committee substitute. The motion passed favorably by voice vote.

Senator Hise recognized Senator Robinson for a motion to consider a proposed committee substitute for HB 823. The motion passed unanimously by voice vote. Representative Carney presented the bill. Senator Pate recognized Rufus Edmisten to speak on the bill. Senators Jim Davis and Tarte discussed the bill. Senator Robinson moved for an unfavorable report as to the bill, but favorable report as to the committee substitute. The motion passed favorably by voice vote.

The meeting adjourned at 11:42 pm.

Senator Ralph Hise
Presiding

Joey Stansbury
Committee Clerk

Senate Committee on Health Care
Tuesday, June 30, 2015, 11:00 AM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 814	The William C. Lindley, Jr. SUDEP Law.	Representative Riddell Representative Ross
HB 823	Establish Advisory Council on Rare Diseases.	Representative Carney Representative Avila Representative Earle Representative Bishop
SB 451	Penalties for Noncompliance.	Senator Tillman

HOUSE BILL 814:
The William C. Lindley, Jr. SUDEP Law

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Judiciary II	**Date:**	June 29, 2015
Introduced by:	Reps. Riddell, Ross	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to Second Edition H814-CSSH-41		

SUMMARY: ***House Bill 814 requires the Office of the Chief Medical Examiner to establish a medical examiner training program that includes training regarding Sudden Unexpected Death in Epilepsy (SUDEP). The PCS mirrors the language in Section 12E.4 of the Senate Budget, but also changes the term sudden "unexplained" to "unexpected" death in epilepsy, removes the requirement that the continuing education be annual, and makes a technical correction to the effective date.***

CURRENT LAW: G.S. 130A-385 outlines the duties of a medical examiner. A medical examiner is responsible for making inquiries regarding the cause and manner of death for each body in his or her charge, reducing the findings to writing, and making a full report to the Chief Medical Examiner. Medical examiners are authorized to inspect and copy medical records of the decedent. Upon completion of the investigation, the medical examiner is required to complete a death certificate, which includes the cause, means or manner of death, including if such a cause, means, or manner is undeterminable.

BILL ANALYSIS: The PCS for House Bill 814 amends G.S. 130A-382 to require the Chief Medical Examiner to appoint two or more county medical examiners. The PCS changes the term sudden "unexplained" death to "unexpected" death and requires continuing education training for county medical examiners that must include training on sudden unexpected death in epilepsy (SUDEP). The PCS deletes the requirement that the training be on an annual basis. The training must be based upon established and published guidelines. The guidelines must be published and annually updated on the Web site of the Office of Chief Medical Examiner. The bill also requires any newly appointed county medical examiners to complete mandatory orientation within 90 days of their appointment.

The bill adds subsection (c) to G.S. 130A-382 to allow the Chief Medical Examiner to revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after giving written notice of the basis for the revocation and opportunity to respond.

EFFECTIVE DATE: The PCS corrects the effective date to provide that the act would become effective January 1, 2016.

BACKGROUND: According to the Epilepsy Foundation, SUDEP "is said to occur when a person with epilepsy dies unexpectedly and was previously in their usual state of health. The death is not known to be related to an accident or seizure emergency such as status epilepticus. When an autopsy is done, no other of cause of death can be found. Each year, more than 1 out of 1,000 people with epilepsy die from SUDEP." [1]

Amy Jo Johnson, former staff to the House Health Committee, contributed to this summary.

[1] http://www.epilepsy.com/sudep-institute

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 814
Committee Substitute Favorable 4/27/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H814-CSSH-41 [v.4]
6/29/2015 4:06:56 PM

Short Title: The William C. Lindley, Jr. SUDEP Law. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING THE CHIEF MEDICAL EXAMINER TO ESTABLISH A MEDICAL EXAMINER TRAINING PROGRAM THAT INCLUDES TRAINING REGARDING SUDDEN UNEXPECTED DEATH IN EPILEPSY DURING MEDICOLEGAL DEATH INVESTIGATIONS.

Whereas, sudden unexpected death in epilepsy (SUDEP) is a mysterious, rare condition in which typically young or middle-aged individuals with epilepsy die without a clear cause, and is generally defined by the medical community as a sudden, unexpected, nontraumatic, nondrowning death in an otherwise healthy individual with epilepsy, where the postmortem examination does not reveal an anatomic or toxicologic cause of the death; and

Whereas, SUDEP is believed to account for up to 17 percent of deaths in individuals with epilepsy; and

Whereas, autopsy plays a key role in determining the diagnosis of SUDEP, yet the Institute of Medicine has found that SUDEP may be underreported for several reasons, including, but not limited to, a lack of awareness about SUDEP among medical examiners; and

Whereas, the cause of SUDEP is not known, and opportunities for its prevention have been hindered by the lack of a systematic effort to collect information about individuals who have died from SUDEP, as is done with many other disorders; and

Whereas, it is appropriate to raise awareness of SUDEP among medical examiners by developing a SUDEP awareness program and by facilitating research into the causes and prevention of SUDEP; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; ~~vacancies.~~vacancies; training requirements; revocation for cause.**

(a) The Chief Medical Examiner shall appoint ~~one~~ two or more county medical examiners for each county for a three-year term. In appointing medical examiners for each county, the Chief Medical Examiner shall give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, ~~coroners,~~ or emergency medical technician paramedics. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so.

(b) County medical examiners shall complete continuing education training as directed by the Office of the Chief Medical Examiner and based upon established and published guidelines for conducting death investigations. The continuing education training shall include

training regarding sudden unexplained death in epilepsy. The Office of the Chief Medical Examiner shall annually update and publish these guidelines on its Internet Web site. Newly appointed county medical examiners shall complete mandatory orientation training as directed by the Office of the Chief Medical Examiner within 90 days of their appointment.

(c) The Chief Medical Examiner may revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after providing the county medical examiner with written notice of the basis for the revocation and an opportunity to respond."

SECTION 2. This act becomes effective January 1, 2016.

HOUSE BILL 814
Committee Substitute Favorable 4/27/15

Short Title: The William C. Lindley, Jr. SUDEP Law. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING THE CHIEF MEDICAL EXAMINER TO ESTABLISH A MEDICAL EXAMINER TRAINING PROGRAM THAT INCLUDES TRAINING REGARDING SUDDEN UNEXPLAINED DEATH IN EPILEPSY DURING MEDICOLEGAL DEATH INVESTIGATIONS.

Whereas, sudden, unexpected death in epilepsy (SUDEP) is a mysterious, rare condition in which typically young or middle-aged individuals with epilepsy die without a clear cause, and is generally defined by the medical community as a sudden, unexpected, nontraumatic, nondrowning death in an otherwise healthy individual with epilepsy, where the postmortem examination does not reveal an anatomic or toxicologic cause of the death; and

Whereas, SUDEP is believed to account for up to 17 percent of deaths in individuals with epilepsy; and

Whereas, autopsy plays a key role in determining the diagnosis of SUDEP, yet the Institute of Medicine has found that SUDEP may be underreported for several reasons, including, but not limited to, a lack of awareness about SUDEP among medical examiners; and

Whereas, the cause of SUDEP is not known, and opportunities for its prevention have been hindered by the lack of a systematic effort to collect information about individuals who have died from SUDEP, as is done with many other disorders; and

Whereas, it is appropriate to raise awareness of SUDEP among medical examiners by developing a SUDEP awareness program and by facilitating research into the causes and prevention of SUDEP; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; ~~vacancies.~~vacancies; training requirements; revocation for cause.**

(a) The Chief Medical Examiner shall appoint one or more county medical examiners for each county for a three-year term. In appointing medical examiners for each county, the Chief Medical Examiner shall give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, ~~coroners,~~ or emergency medical technician paramedics. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so.

(b) County medical examiners shall complete annual continuing education training that shall include training regarding sudden unexplained death in epilepsy, as directed by the Office of the Chief Medical Examiner and based on established and published guidelines. Guidelines shall be published and annually updated on the Web site of the Office of the Chief Medical

Examiner. Newly appointed county medical examiners shall complete mandatory orientation training as directed by the Office of the Chief Medical Examiner within 90 days of their appointment.

(c) The Chief Medical Examiner may revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after giving written notice of the basis for the revocation and opportunity to respond."

SECTION 2. This section becomes effective January 1, 2016.

HOUSE BILL 823

Short Title:	Establish Advisory Council on Rare Diseases.	(Public)
Sponsors:	Representatives Carney, Avila, Earle, and Bishop (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT ESTABLISHING AN ADVISORY COUNCIL ON RARE DISEASES WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

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

"Part 5. Advisory Council on Rare Diseases.

"**§ 130A-33.52. Advisory Council on Rare Diseases; membership.**

(a) There is established the Advisory Council on Rare Diseases within the Department to advise the Secretary on research, diagnosis, treatment, and education relating to rare diseases. For purposes of this section, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb, as amended from time to time.

(b) The advisory council shall consist of the following members, who shall be appointed by the Secretary:

(1) Up to five physicians licensed and practicing in the State with experience researching, diagnosing, or treating rare diseases.

(2) A medical researcher with experience conducting research concerning rare diseases.

(3) A registered nurse or advanced practice registered nurse licensed and practicing in the State with experience treating rare diseases.

(4) One hospital administrator from each hospital in the State that provides care to persons diagnosed with a rare disease, or a designee of the hospital administrator.

(5) Two rare disease survivors over the age of 18.

(6) A caregiver of a pediatric rare disease survivor.

(7) A representative of the North Carolina Board of Education.

(8) A representative in the field of biostatistics.

(9) A representative in the field of public health.

(10) Up to three representatives of patient-based organizations operating within the State.

(c) The chairpersons of the Joint Legislative Oversight Committee on Health and Human Services, or the chairpersons' designees, shall be members of the advisory council.

(d) The Secretary, or the Secretary's designee, shall be an ex officio, nonvoting member of the advisory council and shall attend all meetings of the advisory council.

(e) Any member of the advisory council appointed under subsection (c) of this section may be a member of the General Assembly.

(f) All appointments to the advisory council shall be made not later than 30 days after the effective date of this section. Members appointed pursuant to subsection (b) of this section shall serve for a term of three years, and no member shall serve more than two consecutive terms.

(g) Members of the advisory council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, or travel and subsistence expenses in accordance with the provisions of G.S. 120-3.1, as applicable.

(h) All administrative support and other services required by the advisory council shall be provided by the Department.

(i) The Secretary shall schedule the first meeting of the advisory council, which shall be held not later than October 1, 2015. The members shall elect the chairperson of the advisory council from among the members of the council. A majority of the council members shall constitute a quorum. A majority vote of a quorum shall be required for any official action of the advisory council. The advisory council shall meet upon the call of the chairperson or upon the request of a majority of council members.

"**§ 130A-33.53. Advisory Council on Rare Diseases; powers and duties.**

The advisory council shall exercise the following powers and duties:

(1) Coordinate statewide efforts for the study of the incidence of rare disease within the State and the status of the rare disease community.

(2) Act as the advisory body on rare diseases to the Secretary on research, diagnosis, treatment, and education relating to rare diseases.

(3) Coordinate the performance of the advisory council's duties with other rare disease advisory bodies, community-based organizations, and other public and private organizations within the State for the purpose of ensuring greater cooperation regarding the research, diagnosis, and treatment of rare diseases between the State and federal agencies, including but not exclusive to, the United States National Institutes of Health (NIH) and the United States Food and Drug Administration (FDA). Such coordination shall require, when appropriate, the following:

a. Disseminating the advisory council's research, identified best practices, and policy recommendations.

b. Utilizing common research collection and dissemination procedures.

(4) Research and identify priorities relating to the quality and cost-effectiveness of, and access to, treatment and services provided to persons with rare diseases in the State; and develop policy recommendations on those issues.

(5) Identify best practices for rare disease care from other states and at the national level that will improve rare disease care in this State.

(6) Develop recommendations for effective strategies to raise public awareness of rare diseases in the State.

(7) Determine recommendations for best practices for ensuring that the public and health care providers are sufficiently informed of the most effective strategies for recognizing and treating rare disease.

(8) Develop recommendations for effective strategies to aid in determining any genetic or environmental contributors to rare diseases.

(9) Not later than January 1, 2016, and annually thereafter, the advisory council shall report to the Joint Legislative Oversight Committee on Health and Human Services on the activities of the advisory council and its findings and recommendations regarding rare disease research and care in North Carolina.

(10) Apply for, and accept, any grant of money from the federal government, private foundations, or other sources which may be available for the operation of the advisory council and State programs related to rare diseases."

SECTION 2. This act becomes effective July 1, 2015.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 823
PROPOSED SENATE COMMITTEE SUBSTITUTE H823-CSTA-14 [v.3]

6/29/2015 7:03:54 PM

Short Title: Establish Advisory Council on Rare Diseases. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT ESTABLISHING THE ADVISORY COUNCIL ON RARE DISEASES WITHIN THE SCHOOL OF MEDICINE OF THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL.

The General Assembly of North Carolina enacts:

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

"Part 5. Advisory Council on Rare Diseases.

"**§ 130A-33.52. Advisory Council on Rare Diseases; membership; terms; compensation; meetings; quorum.**

(a) There is established the Advisory Council on Rare Diseases within the School of Medicine of the University of North Carolina at Chapel Hill to advise the Governor, the Secretary, and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases. For purposes of this Part, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb.

(b) Advisory council membership. –

(1) Upon the recommendation of the Dean of the School of Medicine of the University of North Carolina at Chapel Hill, the Secretary shall appoint members to the advisory council as follows:

a. A physician licensed and practicing in this State with experience researching, diagnosing, or treating rare diseases.

b. A medical researcher with experience conducting research concerning rare diseases.

c. A registered nurse or advanced practice registered nurse licensed and practicing in the State with experience treating rare diseases.

d. One rare diseases survivor.

e. One member who represents a rare diseases foundation.

f. One representative from each academic research institution in this State that receives any grant funding for rare diseases research.

(2) The chairs of the Joint Legislative Oversight Committee on Health and Human Services, or the chairs' designees, shall serve on the advisory council. A member of the advisory council who is designated by the chairs of the Joint Legislative Oversight Committee on Health and Human Services may be a member of the General Assembly.

(3) The Secretary, or the Secretary's designee, shall serve as an ex officio, nonvoting member of the advisory council.

(c) Members appointed pursuant to subsection (b) of this section shall serve for a term of three years, and no member shall serve more than two consecutive terms.

(d) Members of the advisory council shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5 or G.S. 138-6, or travel and subsistence expenses in accordance with the provisions of G.S. 120-3.1, as applicable.

(e) All administrative support and other services required by the advisory council shall be provided by the School of Medicine of the University of North Carolina at Chapel Hill.

(f) Upon the recommendation of the Dean of the School of Medicine of the University of North Carolina at Chapel Hill, the Secretary shall select the chair of the advisory council from among the members of the council.

(g) The chair shall convene the first meeting of the advisory council no later than October 1, 2015. A majority of the council members shall constitute a quorum. A majority vote of a quorum shall be required for any official action of the advisory council. Following the first meeting, the advisory council shall meet upon the call of the chair or upon the request of a majority of council members.

"**§ 130A-33.53. Advisory Council on Rare Diseases; powers and duties; reports.**

The advisory council shall have the following powers and duties:

(1) Advise on coordinating statewide efforts for the study of the incidence of rare diseases within the State and the status of the rare disease community.

(2) Report to the Secretary, the Governor, and the Joint Legislative Oversight Committee on Health and Human Services, on behalf of the General Assembly, not later than January 1, 2016, and annually thereafter, on the activities of the advisory council and its findings and recommendations regarding rare disease research and care in North Carolina, including any recommendations for statutory changes and amendments to the structure, organization, and powers or duties of the advisory council."

SECTION 2. All appointments to the Advisory Council on Rare Diseases, established by Section 1 of this act, shall be made not later than 30 days after the effective date of this act.

SECTION 3. This act becomes effective August 1, 2015.

HOUSE BILL 823:
Establish Advisory Council on Rare Diseases

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	June 30, 2015
Introduced by:	Reps. Carney, Avila, Earle, Bishop	**Prepared by:**	Jennifer Mundt Committee Staff
Analysis of:	PCS to First Edition H823-CSTA-14		

SUMMARY: ***The Proposed Committee Substitute (PCS) for House Bill 823 would the Advisory Council on Rare Diseases within the School of Medicine of the University of North Carolina at Chapel Hill.***

BILL ANALYSIS: The PCS for House Bill 823 would establish the Advisory Council on Rare Diseases (Advisory Council) within the School of Medicine of the University of North Carolina at Chapel Hill to advise the Governor, Secretary of Health and Human Services (Secretary), and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases, as that term is defined under federal law[1]. The School of Medicine would provide all administrative support and other services required by the Advisory Council.

The Advisory Council will be comprised of: (i) members with experience or expertise in rare diseases who are appointed by the Secretary, upon the recommendation of the Dean of the School of Medicine; (ii) the chairs of the Joint Legislative Oversight Committee on Health and Human Services (HHS Oversight) or the chairs' designees; and (iii) the Secretary, or the Secretary's designee. Appointments to the Advisory Council must be made no more than 30 days after the effective date of this act. The first meeting of the Advisory Council must be held by October 1, 2015.

The Advisory Council is directed to advise on coordinating statewide efforts for the study of the incidence of rare diseases within the State and the status of the rare disease community. The Advisory Council is directed to the Governor, the Secretary, and HHS Oversight, on behalf of the General Assembly by January 1, 2016, and annually thereafter on its findings and recommendations regarding rare disease research and care in North Carolina, and any recommendations for statutory changes and amendments to the structure, organization, and powers or duties of the Advisory Council.

EFFECTIVE DATE: This act is effective August 1, 2015.

[1] Under 21 U.S.C. § 360bb "rare disease or condition" is defined to mean any disease or condition which (i) affects less than 200,000 persons in the United States, or (ii) affects more than 200,000 in the United States and for which there is no reasonable expectation that the cost of developing and making available in the United States a drug for such disease or condition will be recovered from sales in the United States of such drug.

O. Walker Reagan
Director

H823-SMTA-26 CSTA-14 -V1

Research Division
(919) 733-2578

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Lanier F Hodges	UNC Health Care
Erica McCord	NCHA
Ryan Blackledge	CoreHealth
TJ Bugbee	NP
[illegible]	MD
Martha L McKenzie	Carolines HealthCare
Courtney Johnson	NP
Cory Hand	NCHA
[illegible]	NCMS
Carson Hunt	MVP
JOEL MAYNARD	GPM & ASSOC

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Lexi Morgan Arthur	NCRMA
Ken Melton	K.M.A.
Amber Cassady	ASNC
Mike McBrady	Biogen
[illegible]	School of Law.
[illegible]	[illegible]
Chris McClure	Forensics Pharm
[illegible]	CSS
[illegible]	CSS

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Gasperini	NCMS
Jon Carr	Jordan Price
Fred Bone	Bone : Assoc
Rob Lamme	RLA

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Rufus L. Edmisten	Edmisten & Webb, Morea
Tara Britt	UNC School of Med
Sharon King	Taylor's Tale, Batten Disease
Mary Graff MSN RN	North Carolina Nurses Assoc
Lucy Chartier, Ph.D., NP	Life Quality Resources and Carolina Outreach Raleigh
Tom Friedman	SHP
Austin Pruitt	Perkinson Law
Christopher Tillman	NC Dept of HHS
Alan Scholar	DHHS
Amanda Honaker	Troutman Sanders
Ben Popkin	NCDOI
[illegible]	NMRS

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — June 30, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	DL
Sarah Preston	ACLU-NC
JERRY COHEN	Nelson Mullins
Evan Miller	Nelson Mullins
Thom Mansfield	NCMB
Elizabeth Meredith	NCMB
Olga Ivanenkina	NCMB
Joanna Spruill	NCAFP
Mac Major	ICLG
Andy Chase	NMA
Sarah Woolfe	MWK

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 544

DATE: 6-30 **TIME:** 11 AM

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

Page Name	Hometown	Sponsoring Senator
1. Connor Brown	Ayden	Pate
2. Lauren Hardin	Clinton	B. Jackson
3. Lillie Rhodes	Farmville	D. Davis
4. Mary Allison Page	Gibsonville	Krawiec
5. Abbey Rouse	Clayton	Jackson B.
6. Julia Vaughan-Jones	Mocksville	Brock
7. Logan Jackson	Raleigh	Blue
8. Blake Flinchum	Dobson	Randleman
9. Allison Gallagher	Grimesland	D. Davis
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

Terry Barnhardt

Marcus Kitts

Dale Huff

Senate Committee on Health Care
Tuesday, July 21, 2015 at 11:00 am
Room 544

MINUTES

The Senate Committee on Health Care met at 11:00 am on July 21, 2015 in Room 544. Seventeen members were present. Senator Louis Pate presided.

Senator Pate opened the meeting by recognizing the pages: Anna Deutschle of Charlotte, Sam Stein of Raleigh, Reese Massarelli of Raleigh, Taylor Dozier of Raleigh, Tristian Beard of Goldsboro, Chase Cross of Denton, Endia Punium of Durham and Amber Avens of Roanoke Rapids. Sergeants-at-Arms were: Dale Huff, Terry Barnhardt and Marcus Kitts.

Senator Pate recognized Representative Torbett to explain HB 13 – "Amend School Health Assessment Requirement." A PCS was offered; Sen. Wade moved to accept. Upon explanation of the bill and questions answered, Senator Rabin moved for a favorable report of the Senate Committee Substitute Bill, unfavorable to Committee Substitute Bill with a sequential referral to Education; the motion carried.

Representative Graham was introduced to explain HB 20 - "Reegan's Rule/Childhood Diabetes Education." A PCS was offered; Senator Wade moved to accept. After the explanation of the bill and discussion, Rep. Graham asked Reegan's Mother to speak briefly regarding her daughter's situation which prompted the bill. Senator Davis moved for a favorable report of the PCS, unfavorable to the original bill with a referral to the Insurance Committee; motion carried.

HB 308 – "Clarify Reasonable Health Insurance/Child Support" was next on the agenda. A PCS was offered and accepted by Senator Hise. Senator Pate then recognized Representative Davis to explain the bill. Senator Hise moved for a favorable report to the PCS, unfavorable to the original bill.

Representative Lambeth was recognized to explain HB 724 – "Amend Composition of NC Medical Board." A PCS was offered; Senator Hise moved to accept. Upon completion of the bill explanation, Senator Lowe moved for a favorable report of the PCS, unfavorable as to the original bill. The motion carried.

HB 809 – "Third Party Premium Payments" was last on the agenda. Representative Avila was recognized to explain the bill. A PCS was offered; Senator Rabin moved to accept. After explanation of the bill, members asked numerous questions. Senator Wade moved for a favorable report of the PCS, unfavorable to the original bill with a serial referral to Insurance.

The meeting adjourned at 10:55 am.

Louis M Pate Jr.
Senator Louis Pate, Presiding

Edna Pearce
Edna Pearce, Committee Clerk

SENATE HEALTH COMMITTEE
Tuesday, July 21, 2015
Room 544

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Introduction of Sergeants-at-Arms

BILLS:

BILL NO.	SHORT TITLE	SPONSOR
HB 13	Amend School Health Assessment Requirement	Rep. Torbett Rep. Jones Rep. Pittman Rep. Whitmire
HB 20	Reegan's Rule/Childhood Diabetes Education	Rep. Graham Rep. Glazier
HB 308	Clarify Reasonable Health Ins./Child Support	Rep. Zachary Rep. Stevens Rep. Glazier Rep. Davis
HB 724	Amend Comp. of NC Medical Board	Rep. Lambeth Rep. Malone Rep. S. Martin Rep. Hurley
HB 809	Third-Party Premium Payments	Rep. Avila Rep. Lewis Rep. Collins Rep. Setzer

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, July 21, 2015

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

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

HB **308** Clarify Reasonable Health Insur./Child Supp.

Draft Number:	H308-PCS10419-TV-24
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

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

HB **13** **(CS#1)** Amend School Health Assessment Requirement.

Draft Number:	H13-PCS10420-SH-56
Sequential Referral:	Education/Higher Education
Recommended Referral:	None
Long Title Amended:	Yes

HB **809** **(CS#1)** Third-Party Premium Payments.

Draft Number:	H809-PCS30407-TU-23
Sequential Referral:	Insurance
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Senator Shirley Randleman will handle HB 308
Senator John Barefoot will handle HB 13
Senator Louis Pate will handle HB 809

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, July 21, 2015

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

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

HB **724** Amend Composition of NC Medical Board.

Draft Number:	H724-PCS40486-TA-15
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

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

HB **20** **(CS#1)** Reegans Rule/Childhood Diabetes Education.

Draft Number:	H20-PCS10418-TY-2
Sequential Referral:	None
Recommended Referral:	Insurance
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Ralph Hise will handle HB 724
Senator Jane Smith will handle HB 20

HOUSE BILL 13:
Amend School Health Assessment Requirement

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Education/Higher Education	**Date:**	July 20, 2015
Introduced by:	Rep. Torbett	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to Third Edition H13-CSSH-56		

SUMMARY: The PCS for House Bill 13 does the following: requires each child entering the public schools for the first time to submit proof of a health assessment; provides that absences due to failure to submit the form are not suspensions and allows students to make up the missed work; specifies the information that can be included on the health assessment transmittal form; specifies who has access to the form; requires a report to the Joint Legislative Oversight Committee on Health and Human Services and Joint Legislative Oversight Committee on Education.

CURRENT LAW: G.S. 130A-440 currently requires every child entering kindergarten in the public schools to receive a health assessment. Pursuant to G.S. 130A-441, the health assessment results are submitted on the health assessment transmittal form developed by the Department of Health and Human Services and the Department of Public Instruction.

BILL ANALYSIS: **Section 1** amends the title of Article 18 of Chapter 130A to reflect that under the bill each child entering public school for the first time will be required to have a health assessment, not just those children entering kindergarten. As provided in G.S. 130A-440(d), this Article does not apply to children entering private church schools, schools of religious charter, or qualified nonpublic schools, regulated by Article 39 of Chapter 115C.

Section 2 amends G.S. 130A-440 pertaining to the requirement for health assessments. The current law is amended as follows:

- A child entering public school for the first time at any grade will be required to have a health assessment. Currently only those entering kindergarten are required to have a health assessment.
- The statutes are amended in several places to clarify that there is only one health assessment transmittal form and it is the form developed pursuant to G.S. 130A-441.
- No child is eligible for initial entry into kindergarten or higher grade in the public schools unless a health assessment transmittal form is presented to the school principal. If the health assessment transmittal form is not presented on or before the child's first day of attendance, the principal will submit a notice of deficiency to the parent, guardian, or person standing in loco parentis, who will have 30 calendar days from the first day of attendance to present the form. Upon the termination of 30 calendar days, the principal shall not permit the child to attend school until the form has been presented. This is the current process for kindergarten children and the PCS keeps the timeframe at 30 calendar days.

O. Walker Reagan
Director

H13-SMSH-78 CSSH-56 -V2

Research Division
(919) 733-2578

- The bill provides that a child shall not be suspended for absences accrued for failure to present the health assessment transmittal form and will be allowed to make up work missed in accordance with G.S. 115C-390.2(l) which is contained in Section 4.5 of the bill.
- Consistent with the current law, the health assessment must include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. The permissive language allowing the health assessment to include dental screening and developmental screening has been removed. (The developmental screening and kindergarten entry assessment pursuant to G.S. 115C-83.5 remains in place.)
- Changes are made to ensure consistent references in this section to "parent, guardian, or person standing in loco parentis."

Section 3 amends G.S. 130A-441 pertaining to reporting the health assessment results. The current law does not define what must be included on the health assessment transmittal form developed by the Department of Health and Human Services and the Department of Public Instruction. The PCS provides that the health assessment transmittal form shall include only the following items:

1) A statement that the form will be maintained on file in the school once it has been completed.
2) The **name of the school** the student is attending or will attend.
3) A **student information section** to be completed by the parent, guardian, or person standing in loco parentis for the student that requires the following about the student: first, middle, and last name; date of birth; sex; race; ethnicity; county of residence; and home address.
4) A **parent information section** that includes the following: name of the parent, guardian, or person standing in loco parentis for the student, a telephone number, and space allowing the parent to share any concerns about the student's health with those individuals authorized to have access to the form in subsection (b) of this section.
5) **A section that includes the following information, if applicable, supplied by a health care provider** specified in G.S. 130A-440(c):
    a. A list of medications prescribed for the student.
    b. A list of the student's allergies, the type of allergic reaction, and the response required.
    c. Guidance regarding a special diet for the student.
    d. Health-related recommendations to enhance the student's school performance.
    e. Information on whether the student passed a vision screening and any concerns.
    f. Information on whether the student passed a hearing screening and any concerns.
    g. An opportunity to indicate whether there are recommendations, concerns, or needs related to the student's health and whether school follow-up is needed.
    h. An opportunity to provide comments.
6) **Instructions to the health care provider to attach the student's current immunization record and any of the following applicable school health forms**:
    a. School medication authorization form.
    b. Diabetes care plan.
    c. Asthma action plan.
    d. Health care plans for any other condition for which the school needs to be aware.
7) A certification from the health care provider indicating that they conducted a health assessment in accordance with G.S. 130A-440(b) and that the information on the form is accurate and complete to the best of their knowledge.
8) The date the health assessment was conducted.

9) The health care provider's name, signature, telephone and fax number, and the name and address for the health care provider's practice, and a section for the health care provider's stamp.

The PCS amends G.S. 130A-441(b) to provide that health assessment transmittal form will be maintained on file in the school once it has been submitted. A student's official school record shall only reflect whether or not a health assessment form has been received.

Under current law, the health assessment transmittal form is open to inspection by the DHHS, DPI, or their authorized representatives and persons. The PCS provides that the health assessment transmittal form is open to inspection only by "authorized North Carolina public school administrators, teachers, and other school personnel who require such access to perform their assigned duties, and by authorized employees of the Department of Health and Human Services who require such access to perform their assigned duties." The PCS further specifies that, "Information contained on the health assessment transmittal form is confidential and is not a public record within the meaning of G.S. 132-1."

Section 4.5 amends G.S. 115C-390.2 pertaining to disciplinary policies in order to conform to changes in Section 2 of the bill pertaining to student absences as a result of not submitting the health assessment transmittal form within the required time period.

Section 5 of the PCS requires the Department of Health and Human Services and the Department of Public Instruction to develop a health assessment transmittal form in accordance with the bill and report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee by December 1, 2015.

EFFECTIVE DATE: Sections 1-4.5 of the bill would become effective when they become law and apply to children enrolling in the public schools for the first time beginning with the 2016-17 school year. The remainder of the act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 13
Committee Substitute Favorable 3/17/15
Third Edition Engrossed 3/24/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H13-CSSH-56 [v.5]

7/20/2015 1:33:43 PM

Short Title: Amend School Health Assessment Requirement. (Public)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT TO REQUIRE EACH CHILD PRESENTED FOR ADMISSION INTO THE PUBLIC SCHOOLS FOR THE FIRST TIME TO SUBMIT PROOF OF A HEALTH ASSESSMENT; TO REQUIRE THAT ABSENCES DUE TO THE FAILURE TO PRESENT THE HEALTH ASSESSMENT TRANSMITTAL FORM NOT RESULT IN SUSPENSIONS AND TO ALLOW STUDENTS TO MAKE UP THE WORK MISSED; TO SPECIFY WHAT INFORMATION SHALL BE INCLUDED ON THE HEALTH ASSESSMENT TRANSMITTAL FORM, WHO IS AUTHORIZED TO HAVE ACCESS TO THE FORM, AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE DEPARTMENT OF PUBLIC INSTRUCTION TO AMEND THE HEALTH ASSESSMENT TRANSMITTAL FORM AND TO REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES AND TO THE JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Article 18 of Chapter 130A of the General Statutes reads as rewritten:

"Article 18.

Health Assessments for ~~Kindergarten~~ Children in the Public Schools."

SECTION 2. G.S. 130A-440 reads as rewritten:

"**§ 130A-440. Health assessment required.**

(a) Every parent, or guardian, or person standing in loco parentis shall submit proof of a health assessment for each child in this State ~~entering kindergarten in~~ who is presented for admission into kindergarten or a higher grade in the public schools ~~shall receive a health assessment.~~ for the first time. The health assessment shall be made no more than 12 months prior to the date ~~of school entry.~~ the child would have first been eligible for initial entry into the public schools. No child ~~shall attend kindergarten~~ is eligible for initial entry into kindergarten or a higher grade in the public schools unless a health assessment transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the health assessment required by this section, is presented to the school principal. The only health assessment transmittal form utilized by public schools shall be the form developed pursuant to G.S. 130A-441. The ~~medical provider,~~ health care provider specified in G.S. 130A-440(c), or the parent, guardian, or person standing in loco parentis, must present a completed health assessment transmittal form to the principal of the school on or before the child's first day of attendance. If a health assessment transmittal form is not presented on or before the child's first ~~day,~~day of

attendance, the principal shall present a notice of deficiency to the parent, guardian, or ~~responsible person.~~ person standing in loco parentis. The parent, guardian, or ~~responsible person~~ person standing in loco parentis shall have 30 calendar days from the first day of attendance to present the required health assessment transmittal form for the child. Upon termination of 30 calendar days, the principal shall not permit the child to attend the school until the required health assessment transmittal form has been presented. A child shall not be suspended for absences accrued for failure to present the required health assessment transmittal form upon the termination of 30 calendar days, and the child shall be allowed to make up work missed in accordance with G.S. 115C-390.2(l). It shall be noted in the child's official school record when the health assessment transmittal form has been received.

(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. ~~The health assessment may also include dental screening and developmental screening for cognition, language, and motor function. The developmental screening of cognition and language abilities may be conducted in accordance with G.S. 115C-83.5(a).~~

(c) The health assessment shall be conducted by a physician licensed to practice medicine, a physician's assistant as defined in G.S. 90-18.1(a), a certified nurse practitioner, or a public health nurse meeting the Department's Standards for Early Periodic Screening, Diagnosis, and Treatment Screening.

(d) This Article shall not apply to children entering ~~kindergarten in~~ private church schools, schools of religious charter, or qualified nonpublic schools, regulated by Article 39 of Chapter 115C of the General Statutes.

(e) As used in this section, "parent, guardian, or person standing in loco parentis" means parent, legal guardian, legal custodian, and caregiver adult, as those terms are used in G.S. 115C-366."

SECTION 3. G.S. 130A-441 reads as rewritten:

"**§ 130A-441. Reporting.**

(a) Health assessment results shall be submitted ~~to the school principal by the medical provider~~ on the statewide standardized health assessment transmittal form ~~forms~~ developed by the Department and the Department of Public ~~Instruction.~~ Instruction and submitted to the school principal by the health care provider specified in G.S. 130A-440(c), or the parent, guardian, or person standing in loco parentis for the student. The health assessment transmittal form shall include only the items listed below.

(1) A statement that the form and information on the form will be maintained on file in the school once it has been completed.

(2) The name of the school the student is attending or will attend.

(3) A student information section to be completed by the parent, guardian, or person standing in loco parentis for the student that requires the following about the student: first, middle, and last name; date of birth; sex; race; ethnicity; county of residence; and home address.

(4) A parent information section that includes the following: name of the parent, guardian, or person standing in loco parentis for the student, a telephone number, and space allowing the parent to share any concerns about the student's health with those individuals authorized to have access to the form in subsection (b) of this section.

(5) A section that includes the following information, if applicable, supplied by a health care provider specified in G.S. 130A-440(c):

a. A list of medications prescribed for the student.

b. A list of the student's allergies, the type of allergic reaction, and the response required.

c. Guidance regarding a special diet for the student.
d. Health-related recommendations to enhance the student's school performance.
f. Information on whether the student passed a vision screening and any concerns related to the student's vision.
g. Information on whether the student passed a hearing screening and any concerns related to the student's hearing.
h. An opportunity to indicate whether there are recommendations, concerns, or needs related to the student's health and whether school follow-up is needed.
i. An opportunity to provide comments.

(6) Instructions to the health care provider specified in G.S. 130A-440(c) to attach the student's current immunization record and any of the following applicable school health forms:
a. School medication authorization form.
b. Diabetes care plan.
c. Asthma action plan.
d. Health care plans for any other condition for which the school needs to be aware.

(7) A certification from a health care provider specified in G.S. 130A-440(c) stating: "I certify that I performed on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge."

(8) The date the health assessment was conducted.

(9) The health care provider's name, signature, telephone and fax number, and the name and address for the health care provider's practice.

(10) A section for the health care provider's stamp.

(b) ~~Each school having a kindergarten shall maintain on file the health assessment results.~~ The form will be maintained on file in the school once it has been submitted. A student's official school record shall only reflect whether or not a health assessment transmittal form has been received. The ~~files~~health assessment transmittal form shall be open to inspection only by ~~the Department, the Department of Public Instruction, or their authorized representatives and persons inspecting the files~~ authorized North Carolina public school administrators, teachers, and other school personnel who require such access to perform their assigned duties and by authorized employees of the Department of Health and Human Services who require such access to perform their assigned duties. These personnel shall maintain the confidentiality of the ~~files. Upon transfer of a child to another kindergarten, a copy of the health assessment results shall be provided upon request and without charge to the new kindergarten.~~form. Information contained on the health assessment transmittal form is confidential and is not a public record within the meaning of G.S. 132-1.

(c) Within 60 calendar days after the commencement of a new school year, the principal shall file a health assessment status report with the Department on a form ~~forms~~ developed by the Department and the Department of Public Instruction. The report shall document the number of newly enrolled children in compliance and not in compliance with G.S. 130A-440(a)."

SECTION 4.5. G.S. 115C-390.2 is amended by adding a new subsection to read:

"(l) Board policies shall state that absences under G.S. 130A-440 shall not be suspensions. A student subject to an absence under G.S. 130A-440 shall be provided the following:

(1) The opportunity to take textbooks home for the duration of the absence.

(2) Upon request, the right to receive all missed assignments and, to the extent practicable, the materials distributed to students in connection with the assignment.

(3) The opportunity to take any quarterly, semester, or grading period examinations missed during the absence period."

SECTION 5. The Department of Health and Human Services and the Department of Public Instruction, pursuant to G.S. 130A-441 as amended by this act, shall develop a health assessment transmittal form for the 2016-2017 school year and shall report to the Joint Legislative Oversight Committee on Health and Human Services, and to the Joint Legislative Education Oversight Committee, on the revised health assessment transmittal form on or before December 1, 2015.

SECTION 6. Sections 1 through 4.5 of this act are effective when they become law and apply to children enrolling in the public schools for the first time beginning with the 2016-2017 school year. The remainder of the act is effective when it becomes law.

HOUSE BILL 13
Committee Substitute Favorable 3/17/15
Third Edition Engrossed 3/24/15

Short Title: Amend School Health Assessment Requirement. (Public)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING EACH CHILD PRESENTED FOR ADMISSION INTO THE PUBLIC SCHOOLS FOR THE FIRST TIME TO SUBMIT PROOF OF A HEALTH ASSESSMENT, REQUIRING ABSENCES DUE TO THE FAILURE TO PRESENT THE HEALTH ASSESSMENT TRANSMITTAL FORM NOT BE SUSPENSIONS AND STUDENTS BE ALLOWED TO MAKE UP THE WORK MISSED, AND REQUIRING THE HEALTH ASSESSMENT TRANSMITTAL FORM TO BE PERMANENTLY MAINTAINED IN THE CHILD'S OFFICIAL SCHOOL RECORD.

The General Assembly of North Carolina enacts:

SECTION 1. The title of Article 18 of Chapter 130A of the General Statutes reads as rewritten:

"Article 18.

Health Assessments for ~~Kindergarten~~ Children in the Public Schools."

SECTION 2. G.S. 130A-440 reads as rewritten:

"**§ 130A-440. Health assessment required.**

(a) Every parent, guardian, or person in loco parentis shall submit proof of a health assessment for each child in this State ~~entering kindergarten in~~ who is presented for admission into kindergarten or a higher grade in the public schools ~~shall receive a health assessment.~~for the first time. The health assessment shall be made no more than 12 months prior to the date ~~of school entry.~~the child would have first been eligible for initial entry into the public schools. No child ~~shall attend kindergarten~~ is eligible for initial entry into kindergarten or a higher grade in the public schools unless a health assessment transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the health assessment required by this section, is presented to the school principal. The medical provider, or the parent, guardian, or person in loco parentis, must present a completed health assessment transmittal form to the principal of the school on or before the child's first day of attendance. If a health assessment transmittal form is not presented on or before the child's first ~~day,~~day of attendance, the principal shall present a notice of deficiency to the parent, guardian, or responsible person. The parent, guardian, or responsible person shall have ~~30~~60 calendar days from the first day of attendance to present the required health assessment transmittal form for the child. Upon termination of ~~30~~60 calendar days, the principal shall not permit the child to attend the school until the required health assessment transmittal form has been presented. A child shall not be suspended for absences accrued for failure to present the required health assessment transmittal form upon the termination of 60 calendar days, and the child shall be allowed to make up work

missed in accordance with G.S. 115C-390.2(l). The health assessment transmittal form shall be permanently maintained in the child's official school record.

(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. The health assessment may also include dental screening and developmental screening for cognition, language, and motor function. The developmental screening of cognition and language abilities may be conducted in accordance with G.S. 115C-83.5(a).

(c) The health assessment shall be conducted by a physician licensed to practice medicine, a physician's assistant as defined in G.S. 90-18.1(a), a certified nurse practitioner, or a public health nurse meeting the Department's Standards for Early Periodic Screening, Diagnosis, and Treatment Screening.

(d) This Article shall not apply to children entering ~~kindergarten in~~ private church schools, schools of religious charter, or qualified nonpublic schools, regulated by Article 39 of Chapter 115C of the General Statutes."

SECTION 3. G.S. 130A-441 reads as rewritten:

"**§ 130A-441. Reporting.**

(a) Health assessment results shall be submitted to the school principal by the medical provider on health assessment transmittal forms developed by the Department and the Department of Public Instruction.

(b) ~~Each school having a kindergarten shall maintain on file the health assessment results.~~ The health assessment transmittal form shall be permanently maintained in the student's official school record. The ~~files~~health assessment transmittal form shall be open to inspection only by the Department, the Department of Public Instruction, or their authorized representatives and persons inspecting the ~~files~~forms shall maintain the confidentiality of the ~~files. Upon transfer of a child to another kindergarten, a copy of the health assessment results shall be provided upon request and without charge to the new kindergarten.~~forms.

(c) Within ~~60~~90 calendar days after the commencement of a new school year, the principal shall file a health assessment status report with the Department on forms developed by the Department and the Department of Public Instruction. The report shall document the number of newly enrolled children in compliance and not in compliance with G.S. 130A-440(a)."

SECTION 4. G.S. 115C-402(b) reads as rewritten:

"(b) The official record shall contain, ~~as~~ at a minimum, adequate identification data including date of birth, attendance data, grading and promotion ~~data,~~ data; a health assessment transmittal form as required by G.S. 130A-440; and such other factual information as may be deemed appropriate by the local board of education having jurisdiction over the school wherein the record is maintained. Each student's official record also shall include notice of any long-term suspension or expulsion imposed pursuant to G.S. 115C-390.7 through G.S. 115C-390.11 and the conduct for which the student was suspended or expelled. The superintendent or the superintendent's designee shall expunge from the record the notice of suspension or expulsion if the following criteria are met:

(1) One of the following persons makes a request for expungement:
   a. The student's parent, legal guardian, or custodian.
   b. The student, if the student is at least 16 years old or is emancipated.

(2) The student either graduates from high school or is not expelled or suspended again during the two-year period commencing on the date of the student's return to school after the expulsion or suspension.

(3) The superintendent or the superintendent's designee determines that the maintenance of the record is no longer needed to maintain safe and orderly schools.

(4) The superintendent or the superintendent's designee determines that the maintenance of the record is no longer needed to adequately serve the child."

SECTION 4.5. G.S. 115C-390.2 is amended by adding a new subsection to read:

"(l) Board policies shall state that absences under G.S. 130A-440 shall not be suspensions. A student subject to an absence under G.S. 130A-440 shall be provided the following:

(1) The opportunity to take textbooks home for the duration of the absence.

(2) Upon request, the right to receive all missed assignments and, to the extent practicable, the materials distributed to students in connection with the assignment.

(3) The opportunity to take any quarterly, semester, or grading period examinations missed during the absence period."

SECTION 5. This act is effective when it becomes law and applies to children enrolling in the public schools for the first time beginning with the 2015-2016 school year.

HOUSE BILL 20:
Reegan's Rule/Childhood Diabetes Education

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	July 21, 2015
Introduced by:	Rep. C. Graham	**Prepared by:**	Jennifer Mundt
Analysis of:	PCS to Third Edition		Augustus Willis
	H20-CSTY-2		Committee Staff

SUMMARY: The Proposed Committee Substitute (PCS) for House Bill 20 would: (i) encourage parent education during well-child visits at specific age intervals regarding Type I diabetes and (ii) subject Pharmacy Benefits Managers to the same civil penalties and restitution provisions as other persons subject to licensure or certification under Chapter 58 of the General Statutes.

[As introduced, this bill was identical to S27, as introduced by Sen. Smith, which is currently in Senate Health Care.]

CURRENT LAW and BILL ANALYSIS:

Section 1: Encourages each physician, physician's assistant, or certified nurse practitioner who provides well-child care to educate and discuss the warning signs of Type I diabetes and symptoms with the parents of each child under their care at birth, and at yearly intervals until the age of five.

Pharmacy Benefits Managers (PBMs) process prescriptions for groups that pay for drugs, such as insurance companies or corporations, by acting as an intermediary between the payor and other members of the health system. Currently, pursuant to G.S. 58-56A, PBMs may place a particular drug on a "Maximum Allowable Cost" (MAC) price list, provided the drug meets certain criteria. Once a PBM places a drug on a MAC list, it is required to conduct a review of the MAC prices for potential removal or modification at least once every seven business days and, if necessary, modify the MAC price of the drug or remove it from the MAC price list within seven business days of the review.

Section 2: Rewrites G.S. 58-2-70 in order to specifically include PBMs within the list of persons to whom civil penalties apply for violations of Chapter 58 (Insurance). A PBM who fails to review its MAC price list and make the necessary modifications or removal within the seven business day time period mandated by state law would be subject to the same penalties as any person subject to licensure under Chapter 58, including:

- a monetary penalty at the discretion of the Commissioner of Insurance (Commissioner) in an amount of between $100 and $1,000 per violation; and/or
- restitution in an amount that would make whole any person harmed by the violation if ordered by the Superior Court of Wake County after petition by the Commissioner.

It also gives the Commissioner discretion to impose an additional monetary penalty of up to $1,000 for each prescription found to have been improperly reimbursed as a result of a PBM's failure to comply with its duty to review and modify drugs on its MAC price list.

EFFECTIVE DATE: Section 1 becomes effective October 1, 2015. Section 2 is effective when this act becomes law.

O. Walker Reagan
Director

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Research Division
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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 20
Committee Substitute Favorable 4/27/15
Third Edition Engrossed 4/29/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H20-CSTY-2 [v.5]
7/20/2015 6:01:39 PM

Short Title: Reegan's Rule/Enforce Pharm. Ben. Mgt. (Public)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT TO (1) ENCOURAGE PARENT EDUCATION DURING WELL-CHILD VISITS AT SPECIFIC AGE INTERVALS REGARDING TYPE I DIABETES AND (2) TO AMEND THE LAW PERTAINING TO PHARMACY BENEFIT MANAGERS.

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-221.5. Diabetes education as part of well-child care.**

Each physician, physician assistant, or certified nurse practitioner who provides well-child care is encouraged to educate and discuss the warning signs of Type I diabetes and symptoms with each parent for each child under the care of the physician, physician assistant, or certified nurse practitioner at least once at the following age intervals:

(1) Birth.
(2) Twelve months of age.
(3) Twenty-four months of age.
(4) Thirty-six months of age.
(5) Forty-eight months of age.
(6) Sixty months of age."

SECTION 2. G.S. 58-2-70 reads as rewritten:

"**§ 58-2-70. Civil penalties or restitution for violations; administrative procedure.**

(a) This section applies to any person who ~~is subject to licensure or certification under this Chapter.~~is either:

(1) Subject to licensure or certification under this Chapter; or
(2) A pharmacy benefits manager as defined in G.S. 58-56A-1.

(b) ~~Whenever the Commissioner has reason to believe that any person has violated any of the provisions of this Chapter, and the violation subjects the license or certification of that person to suspension or revocation, the Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section.~~ The Commissioner may, after notice and opportunity for a hearing, proceed under the appropriate subsections of this section whenever the Commissioner has reason to believe:

(1) That any person has violated any of the provisions of this Chapter, and the violation subjects the license or certification of that person to suspension or revocation; or
(2) That a pharmacy benefits manager has violated G.S. 58-56A-5.

(c) If, under subsection (b) of this section, the Commissioner finds a violation of this Chapter, the Commissioner may, in addition to or instead of suspending or revoking the license or certification, order the payment of a monetary penalty as provided in subsection (d) of this section or petition the Superior Court of Wake County for an order directing payment of restitution as provided in subsection (e) of this section, or both. Each day during which a violation occurs constitutes a separate violation.

(d) If the Commissioner orders the payment of a monetary penalty pursuant to subsection (c) of this section, the penalty shall not be less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000). In determining the amount of the penalty, the Commissioner shall consider the degree and extent of harm caused by the violation, the amount of money that inured to the benefit of the violator as a result of the violation, whether the violation was committed willfully, and the prior record of the violator in complying or failing to comply with laws, rules, or orders applicable to the violator. The clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. Payment of the civil penalty under this section shall be in addition to payment of any other penalty for a violation of the criminal laws of this State.

(d1) In the case of a monetary penalty imposed upon a Pharmacy Benefits Manager found to have violated G.S. 58-56A-5, the Commissioner may, at his discretion, impose an additional penalty of up to $1,000 per prescription, for each prescription found to have been improperly reimbursed as a result of the Pharmacy Benefits Manager's failure to comply with G.S. 58-56A-5. This subsection shall apply only to Pharmacy Benefits Managers as defined in G.S. 58-56A-1.

(e) Upon petition of the Commissioner the court may order the person who committed a violation specified in subsection (c) of this section to make restitution in an amount that would make whole any person harmed by the violation. The petition may be made at any time and also in any appeal of the Commissioner's order.

(f) Restitution to any State agency for extraordinary administrative expenses incurred in the investigation and hearing of the violation may also be ordered by the court in such amount that would reimburse the agency for the expenses.

(g) Nothing in this section prevents the Commissioner from negotiating a mutually acceptable agreement with any person as to the status of the person's license or certificate or as to any civil penalty or restitution.

(h) Unless otherwise specifically provided for, all administrative proceedings under this Chapter are governed by Chapter 150B of the General Statutes. Appeals of the Commissioner's orders under this section shall be governed by G.S. 58-2-75."

SECTION 3. Section 1 of this act becomes effective October 1, 2015. The remaining sections of this act become effective when this act becomes law.

HOUSE BILL 20
Committee Substitute Favorable 4/27/15
Third Edition Engrossed 4/29/15

Short Title: Reegan's Rule/Childhood Diabetes Education. (Public)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT REQUIRING PARENT EDUCATION DURING WELL-CHILD VISITS AT SPECIFIC AGE INTERVALS REGARDING TYPE I DIABETES.

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-221.5. Diabetes education as part of well-child care.**

Each physician, physician assistant, or certified nurse practitioner who provides well-child care is encouraged to educate and discuss the warning signs of Type I diabetes and symptoms with each parent for each child under the care of the physician, physician assistant, or certified nurse practitioner at least once at the following age intervals:

(1) Birth.
(2) Twelve months of age.
(3) Twenty-four months of age.
(4) Thirty-six months of age.
(5) Forty-eight months of age.
(6) Sixty months of age."

SECTION 2. This act becomes effective October 1, 2015.

HOUSE BILL 308: Clarify Reasonable Health Insur/LTC Ombudsman

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	July 20, 2015
Introduced by:	Reps. Zachary, Stevens, Glazier, Davis	**Prepared by:**	Theresa Matula Legislative Analyst and Tawanda Foster Committee Counsel
Analysis of:	PCS to First Edition H308-CSTV-24		

SUMMARY: The PCS to House Bill 308 would amend laws pertaining to medical support and health insurance coverage relating to child support to align state law and federal guidelines and would modify the Long-Term Care Ombudsman Program to conform with federal requirements. The PCS would add Section 2 to the Bill.

CURRENT LAW: G.S. 50-13.11 requires the court to order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when the insurance is available at a reasonable cost. Employer-provided group health insurance is automatically considered reasonable.

Part 14D of Chapter 143B of the General Statutes establishes and specifies the requirements for the Long-Term Care Ombudsman Program.

BILL ANALYSIS: Section 1 of the PCS would provide that health insurance is available at a reasonable cost to the parent if it does not exceed 5% of the parent's gross income. The cost is defined as the cost of (i) adding the child to the parent's existing coverage; (ii) child-only coverage; or (iii) if new coverage must be obtained, the difference between the cost of self-only and family coverage.

Section 2 of the PCS would make conforming and technical changes to the Long-Term Care Ombudsman Program required by federal law.

EFFECTIVE DATE: Section 1 is effective when it becomes law and applies to orders issued or agreements entered into on or after that date. Section 2 becomes effective July 1, 2016.

BACKGROUND: The Long-Term Care Ombudsman Program was designed to address the concerns of consumers in long-term care facilities and their families. The Program also provides education for consumers and the public about Elder Abuse Awareness and Prevention. The Administration on Aging of the Administration for Community Living within the U.S. Department of Health and Human Services issued a final rule to implement provisions of the Older Americans Act (42 U.S.C. § 3001 et seq.) regarding States' Long-Term Care Ombudsman programs. North Carolina must update its statutes, regulations, policies, procedures and practices in order to operate the Ombudsman program consistent with federal law and the final rule.

O. Walker Reagan
Director

H308-SMTV-52 CSTV-24 -V5

Research Division
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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 308
PROPOSED SENATE COMMITTEE SUBSTITUTE H308-CSTV-24 [v.7]

7/20/2015 5:28:35 PM

Short Title: Clarify Reasonable Health Insur/LTC Ombudsman. (Public)

Sponsors:

Referred to:

March 23, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE MEDICAL SUPPORT AND HEALTH INSURANCE COVERAGE RELATING TO CHILD SUPPORT TO ALIGN STATE LAW WITH FEDERAL GUIDELINES THAT NO LONGER INCLUDE THE PROVISION THAT EMPLOYER-PROVIDED GROUP HEALTH INSURANCE IS AUTOMATICALLY CONSIDERED "REASONABLE"; AND TO MODIFY THE LONG-TERM CARE OMBUDSMAN PROGRAM TO CONFORM WITH FEDERAL GUIDELINES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 50-13.11(a1) reads as rewritten:

"(a1) The court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance is available at a reasonable cost. If health insurance is not presently available at a reasonable cost, the court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance becomes available at a reasonable cost. As used in this subsection, health insurance for the benefit of the child is considered reasonable in cost if ~~it is employment related or other group health insurance, regardless of service delivery mechanism.~~ the coverage for the child is available at a cost to the parent that does not exceed five percent (5%) of the parent's gross income. In applying this standard the cost is the cost of: (i) adding the child to the parent's existing coverage, (ii) child-only coverage; or (iii) if new coverage must be obtained, the difference between the cost of self-only and family coverage. The court may require one or both parties to maintain dental insurance."

SECTION 2. Part 14D of Chapter 143B of the General Statutes reads as rewritten:

"Part 14D. Long-Term Care Ombudsman Program.

"§ 143B-181.15. Long-Term Care Ombudsman Program/Office; policy.

The General Assembly finds that a significant number of older citizens of this State reside in long-term care facilities and are dependent on others to provide their care. It is the intent of the General Assembly to protect and improve the quality of care and life for residents through the establishment of a program to assist residents and providers in the resolution of complaints or common concerns, to promote community involvement and volunteerism in long-term care facilities, and to educate the public about the long-term care system. It is the further intent of the General Assembly that the Department of Health and Human Services, within available resources and pursuant to its duties under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq., and regulations promulgated thereunder, ensure that the quality of care and life for these residents is maintained, that necessary reports are made, and that, when necessary, corrective action is taken at the Department level.

"**§ 143B-181.16. Long-Term Care Ombudsman Program/Office; definition.**

Unless the content clearly requires otherwise, as used in this Article:

(1) "Long-term care facility" means any skilled nursing facility and intermediate care facility as defined in G.S. 131A-3(4) or any adult care home as defined in G.S. 131D-20(2).

(1b) "Programmatic supervision" means the monitoring of the performance of the duties of the Regional Ombudsman and ensuring that the Area Agency on Aging does not have personnel policies or practices that conflict with the laws and policies governing the Ombudsman program as performed by the State Ombudsman.

(1c) "Regional Ombudsman" means a person employed by an Area Agency on Aging who is certified and designated by the State Ombudsman to carry out the functions of the Regional Ombudsman Office established by this Article, 42 U.S.C. § 3001, et. seq., and regulations promulgated thereunder.

(2) "Resident" means any person who is receiving treatment or care in any long-term care facility.

(3) "State Ombudsman" means the State Ombudsman as defined by the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq., and regulations promulgated thereunder, who carries out the duties and functions established by this Article and 42 U.S.C. § 3001, et. seq. and regulations promulgated thereunder.

(4) "Willful interference" means actions or inactions taken by an individual in an attempt to intentionally prevent, interfere with, or attempt to impede the Ombudsman or a representative of the Office from performing any of the functions, responsibilities, or duties set forth in 42 U.S.C. § 3001 et. seq., and regulations promulgated thereunder.

"**§ 143B-181.17. Office of State Long-Term Care Ombudsman Program/Office; establishment.**

The Secretary of Department of Health and Human Services shall establish and maintain the Office of State Long-Term Ombudsman in the Division of Aging. The Office shall carry out the functions and duties required by the Older Americans Act of 1965, as ~~amended~~ amended, and as set forth in 42 U.S.C. § 3001 et. seq. and regulations promulgated thereunder. This Office shall be headed by a State Ombudsman who is a person qualified by training and with experience in geriatrics and long-term care. The Attorney General shall provide legal staff and advice to this Office.

"**§ 143B-181.18. Office of State Long-Term Care Ombudsman Program/State Ombudsman duties.**

The State Ombudsman ~~shall:~~ shall peform the duties provided below.

(1) Promote community involvement with long-term care providers and residents of long-term care facilities and serve as liaison between residents, residents' families, facility personnel, and facility ~~administration;~~ administration.

(2) Supervise the Long-Term Care Program pursuant to rules adopted by the Secretary of the Department of Health and Human Services pursuant to G.S. ~~143B-10;~~ 143B-10.

(3) Certify regional ombudsmen. Certification requirements shall include an internship, training in the aging process, complaint resolution, long-term care issues, mediation techniques, recruitment and training of volunteers, and relevant federal, State, and local laws, policies, and ~~standards;~~ standards.

(3a) Designate certified regional ombudsmen as representatives of the State Ombudsman Office as well as refuse, suspend or remove designation as a

representative of the Office in accordance with the Office of the State Ombudsman Policies and Procedures.

(4) Attempt to resolve complaints made by or on behalf of individuals who are residents of long-term care facilities, which complaints relate to administrative action that may adversely affect the health, safety, or welfare of ~~residents;~~ residents.

(5) Provide training and technical assistance to regional ~~ombudsmen;~~ ombudsmen.

(6) Establish procedures for appropriate access by regional ombudsmen to long-term care facilities and residents' files, ~~records~~ records, and other information -including procedures to protect the confidentiality of these files, ~~records~~ records, and other information and to ensure that the identity of any complainant or resident will not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq. and regulations promulgated thereunder.

(7) Analyze data relating to complaints and conditions in long-term care facilities to identify significant problems and recommend ~~solutions;~~ solutions.

(8) Prepare an annual report containing data and findings regarding the types of problems experienced and complaints reported by residents as well as recommendations for resolutions of identified long-term care ~~issues;~~ issues.

(9) Prepare findings regarding public education and community involvement efforts and innovative programs being provided in long-term care ~~facilities; and~~ facilities.

(10) Provide information to public agencies, and through the State Ombudsman, to legislators, and others regarding problems encountered by residents or providers as well as recommendations for resolution.

(11) Provide leadership for statewide systems advocacy efforts of the Office on behalf of long-term care residents, including independent determinations and positions that shall not be required to represent the position of the State agency or other agency within which the Ombudsman Program is organizationally located. Provide coordination of systems advocacy efforts with representatives of the Office as outlined in Ombudsman Policies and Procedures.

(12) To the extent required to meet the requirement of the Older Americans Act and regulations promulgated thereunder regarding allotments for Vulnerable Elder Rights Protection Activities, the State Ombudsman and representatives of the Office are excluded from any State lobbying prohibitions under requirements to conduct systems advocacy on behalf of long-term care residents.

(13) Determine the use of the fiscal resources appropriated or otherwise available for the operations of the Office, including approval of allocations provided for local program budgets that are consistent with laws, policies and procedures governing the Ombudsman Program.

"**§ 143B-181.19. Office of Regional Long-Term Care Ombudsman; Regional Ombudsman; duties.**

(a) An Office of Regional Ombudsman Program shall be established in each of the Area Agencies on Aging, and shall be headed by a designated Regional Ombudsman who shall carry out the functions and duties of the Office. The State Long-Term Care Ombudsman shall designate all Regional Ombudsmen housed within the Area Agency. The Area ~~Agency~~ Agencies on Aging ~~administration~~ shall provide administrative supervision to each Regional

Ombudsman limited to the Agency's personnel policies pertaining to time and attendance, benefits, assigned work space and equipment, and general operations of the Agency. The State Ombudsman shall ensure that the Area Agency does not have personnel policies or practices that conflict with the laws and policies governing the Ombudsman program.

(b) Pursuant to policies and procedures established by the State Office of Long-Term Care Ombudsman, ~~the~~ a Regional Ombudsman shall:

(1) Promote community involvement with long-term care facilities and residents of long-term care facilities and serve as a liaison between residents, residents' families, facility personnel, and facility administration;

(2) Receive and attempt to resolve complaints made by or on behalf of residents in long-term care facilities;

(3) Collect data about the number and types of complaints handled;

(4) Work with long-term care providers to resolve issues of common concern;

(5) Work with long-term care providers to promote increased community involvement;

(6) Offer assistance to long-term care providers in staff training regarding residents' rights;

(7) Report regularly to the office of State Ombudsman about the data collected and about the activities of the Regional Ombudsman;

(8) Provide training and technical assistance to the community advisory committees; and

(9) Provide information to the general public on long-term care issues and with the authorization of the Office of the State Long-Term Care Ombudsman conduct systems advocacy activities on behalf of long-term care residents.

"§ 143B-181.20. State/Regional Long-Term Care Ombudsman; authority to enter; cooperation of government agencies; communication with residents.

(a) The State and Regional Ombudsman may enter any long-term care facility at any time during regular visiting hours or at any other time when access may be required by the circumstances to be investigated, and may have ~~reasonable~~ access to any resident in the ~~reasonable~~ pursuit of his function. The Ombudsman may communicate privately and confidentially with residents of the facility individually or in groups. The Ombudsman shall have access to the ~~patient~~ resident's files, records, and other information as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq., and regulations promulgated thereunder, and under procedures established by the State Ombudsman pursuant to G.S. 143B-181.18(6). Entry shall be conducted in a manner that will not significantly disrupt the provision of nursing or other care to residents and if the long-term care facility requires registration of all visitors entering the facility, then the State or Regional Ombudsman must also register. Any State or Regional Ombudsman who discloses any information obtained from the ~~patient's~~ resident's records except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq. and regulations promulgated thereunder, is guilty of a Class 1 misdemeanor.

(b) The State or Regional Ombudsman shall identify himself as such to the resident, and the resident has the right to refuse to communicate with the Ombudsman.

(c) The resident has the right to participate in planning any course of action to be taken on his behalf by the State or Regional Ombudsman, and the resident has the right to approve or disapprove any proposed action to be taken on his behalf by the Ombudsman.

(d) The State or Regional Ombudsman shall meet with the facility administrator or person in charge before any action is taken to allow the facility the opportunity to respond, provide additional information, or take appropriate action to resolve the concern.

(e) The State and Regional Ombudsman may obtain from any government agency, and this agency shall provide, that cooperation, assistance, services, data, and access to files and

records that will enable the Ombudsman to properly perform his duties and exercise his powers, provided this information is not privileged by law.

(f) If the subject of the complaint involves suspected abuse, neglect, or exploitation, the ~~State or~~ Regional Ombudsman shall only with the written informed consent of the resident or authorization by the State Ombudsman notify the ~~county department of social services'~~ Adult Protection Services section of the county department of social ~~services,~~ services. Except as provided herein, the State or Regional Ombudsman is not subject to the reporting requirements of ~~pursuant to~~ Article 6 of Chapter 108A of the General Statutes.

"**§ 143B-181.21. State/Regional Long-Term Care Ombudsman; resolution of complaints.**

(a) Following receipt of a complaint, the State or Regional Ombudsman shall attempt to resolve the complaint using, whenever possible, informal techniques of mediation, conciliation, and persuasion.

(b) Complaints or conditions adversely affecting residents of long-term care facilities that cannot be resolved in the manner described in subsection (a) of this section shall be referred by the State or Regional Ombudsman to the appropriate licensure agency pursuant to G.S. 131E-100 through 110 and Part 1 of Article 1 of Chapter 131D of the General Statutes.

"**§ 143B-181.22. State/Regional Long-Term Care Ombudsman; confidentiality.**

The identity of any complainant, resident on whose behalf a complaint is made, or any individual providing information on behalf of the resident or complainant relevant to the attempted resolution of the complaint along with the files, records and other information produced by the process of complaint resolution is confidential and shall be disclosed only as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq.

"**§ 143B-181.23. State/Regional Long-Term Care Ombudsman; prohibition of retaliation.**

No person shall discriminate or retaliate in any manner against any resident or relative or guardian of a resident, any employee of a long-term care facility, or any other person because of the making of a complaint or providing of information in good faith to the State Ombudsman or Regional Ombudsman. The State Ombudsman shall determine instances of discrimination or retaliation and assess a monetary penalty in the amount of $2500 per incident. The Department shall adopt rules pertaining to this determination of discrimination or retaliation.

"**§ 143B-181.24. Office of State/Regional Long-Term Care Ombudsman; immunity from liability.**

No representative of the Office shall be liable for good faith performance of official duties.

"**§ 143B-181.25. Office of State/Regional Long-Term Care Ombudsman; penalty for willful interference.**

Willful or unnecessary obstruction with the State or Regional Long-Term Care Ombudsman in the performance of his official duties is a Class 1 misdemeanor and subject to a fine of $2500."

SECTION 3. Section 1 and Section 3 of this act is effective when it becomes law and applies to orders issued or agreements entered into on or after that date. Section 2 of this act becomes effective July 1, 2016.

HOUSE BILL 308

Short Title:	Clarify Reasonable Health Insur./Child Supp.	(Public)
Sponsors:	Representatives Zachary, Stevens, Glazier, and Davis (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Judiciary III, if favorable, Insurance.	

March 23, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS PERTAINING TO THE MEDICAL SUPPORT AND HEALTH INSURANCE COVERAGE RELATING TO CHILD SUPPORT TO ALIGN STATE LAW WITH FEDERAL GUIDELINES THAT NO LONGER INCLUDE THE PROVISION THAT EMPLOYER-PROVIDED GROUP HEALTH INSURANCE IS AUTOMATICALLY CONSIDERED "REASONABLE."

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 50-13.11(a1) reads as rewritten:

"(a1) The court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance is available at a reasonable cost. If health insurance is not presently available at a reasonable cost, the court shall order the parent of a minor child or other responsible party to maintain health insurance for the benefit of the child when health insurance becomes available at a reasonable cost. As used in this subsection, health insurance for the benefit of the child is considered reasonable in cost if (i) it is employment related or other group health insurance, ~~regardless of service delivery mechanism.~~and (ii) the coverage for the child is available to the parent at a cost that does not exceed seven percent (7%) of the parent's gross income. The court may require one or both parties to maintain dental insurance."

SECTION 2. This act is effective when it becomes law and applies to orders issued or agreements entered into on or after that date.

HOUSE BILL 724:
Amend Composition of NC Medical Board

2015-2016 General Assembly

Committee:	Senate Health Care	**Date:**	July 21, 2015
Introduced by:	Reps. Lambeth, Malone, S. Martin, Hurley	**Prepared by:**	Jennifer Mundt Committee Staff
Analysis of:	PCS to First Edition H724-CSTA-15 [v.2]		

SUMMARY: House Bill 724 would revise the membership of the North Carolina Medical Board to provide that at least one physician assistant and at least one nurse practitioner must serve as members of the Board.

The Proposed Committee Substitute (PCS) makes conforming changes.

CURRENT LAW: Pursuant to G.S. 90-2, the North Carolina Medical Board (Board) is made up of 12 members who are directed to regulate the practice of medicine and surgery for the benefit of the people of the State. The Board is comprised of 12 members as follows:

- 7 members who are licensed physicians, as recommended by the Review Panel[1] and approved by the Governor
- 5 members appointed by the Governor:
  - 1 licensed physician who is a doctor of osteopathy or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in that person's clinical practice or a member of The Old North State Medical Society.
  - 3 public members who are not health care providers or the spouse of a health care provider.
  - *1 physician assistant **OR** 1 nurse practitioner.*

BILL ANALYSIS: House Bill 724 would increase the membership of the Board from 12 to 13 members. The addition of the new member ensures that the composition of the Board includes both a physician assistant and a nurse practitioner.

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

[1] The Review Panel is directed to review all applications for the physician, physician assistant, and nurse practitioner positions on the Board (G.S. 90-3).

O. Walker Reagan
Director

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 724
PROPOSED SENATE COMMITTEE SUBSTITUTE H724-CSTA-15 [v.2]

7/20/2015 12:06:05 PM

Short Title: Amend Composition of NC Medical Board. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO REVISE THE MEMBERSHIP OF THE NORTH CAROLINA MEDICAL BOARD TO ENSURE THAT AT LEAST ONE PHYSICIAN ASSISTANT AND AT LEAST ONE NURSE PRACTITIONER SERVE AS MEMBERS OF THE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2(a) reads as rewritten:

"(a) There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of ~~12~~ 13 members.

(1) Seven of the members shall be duly licensed physicians recommended by the Review Panel and appointed by the Governor as set forth in G.S. 90-3.

(2) The remaining ~~five~~ six members shall all be appointed by the Governor as follows:

a. One shall be a duly licensed physician who is a doctor of osteopathy or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in that person's clinical practice or a member of The Old North State Medical Society. This Board position shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3.

b. Three shall be public members, and these Board positions shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3. A public member shall not be a health care provider nor the spouse of a health care provider. For the purpose of Board membership, "health care provider" means any licensed health care professional, agent or employee of a health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this section, a person enrolled in a program as preparation to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

c. One shall be a physician assistant as defined in G.S. 90-18.1 ~~or a nurse practitioner as defined in G.S. 90-18.2~~ as recommended by the Review Panel pursuant to G.S. 90-3.

d. One shall be a nurse practitioner as defined in G.S. 90-18.2 as recommended by the Review Panel pursuant to G.S. 90-3."

SECTION 2. G.S. 90-3 reads as rewritten:

§ 90-3. Review Panel recommends certain Board members; criteria for recommendations.

"(a) There is created a Review Panel to review all applicants for the physician positions ~~and~~ the physician ~~assistant or~~assistant position, and the nurse practitioner position on the Board except as provided in G.S. 90-2(a)(2)a. The Review Panel shall consist of nine members, including four from the Medical Society, one from the Old North State Medical Society, one from the North Carolina Osteopathic Medical Association, one from the North Carolina Academy of Physician Assistants, one from the North Carolina Nurses Association Council of Nurse Practitioners, and one public member currently serving on the Board. All physicians, physician assistants, and nurse practitioners serving on the Review Panel shall be actively practicing in North Carolina.

The Review Panel shall contract for the independent administrative services needed to complete its functions and duties. The Board shall provide funds to pay the reasonable cost for the administrative services of the Review Panel. The Board shall convene the initial meeting of the Review Panel. The Review Panel shall elect a chair, and all subsequent meetings shall be convened by the Review Panel.

The Governor shall appoint Board members as provided in G.S. 90-2. The Review Panel shall attempt to make its recommendations to the Governor reflect the composition of the State with regard to gender, ethnic, racial, and age composition.

The Review Panel and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law.

(b) To be considered qualified for a physician ~~position or~~position, the physician assistant position, or nurse practitioner position on the Board, an applicant shall meet each of the following criteria:

(1) Hold an active, nonlimited license to practice medicine in North Carolina, or in the case of a physician assistant ~~or~~ and nurse practitioner, hold an active license or approval to perform medical acts, tasks, and functions in North Carolina.

(2) Have an active clinical or teaching practice. For purposes of this subdivision, the term "active" means patient care, or instruction of students in an accredited medical school or residency, or clinical research program, for 20 hours or more per week.

(3) Have actively practiced in this State for at least five consecutive years immediately preceding the appointment.

(4) Intend to remain in active practice in this State for the duration of the term on the Board.

(5) Submit at least three letters of recommendation, either from individuals or from professional or other societies or organizations.

(6) Have no public disciplinary history with the Board or any other licensing board in this State or another state over the past 10 years before applying for appointment to the Board.

(7) Have no history of felony convictions of any kind.

(8) Have no misdemeanor convictions related to the practice of medicine.

(9) Indicate, in a manner prescribed by the Review Panel, that the applicant: (i) understands that the primary purpose of the Board is to protect the public; (ii) is willing to take appropriate disciplinary action against his or her peers for misconduct or violations of the standards of care or practice of medicine;

and (iii) is aware of the time commitment needed to be a constructive member of the Board.

(c) The ~~review panel~~Review Panel shall recommend at least two qualified nominees for each open position on the Board. If the Governor chooses not to appoint either of the recommended nominees, the Review Panel shall recommend at least two new qualified nominees.

(d) Notice of open ~~physician positions or the physician assistant or nurse practitioner position~~physician, physician assistant, or nurse practitioner positions on the Board shall be sent to all physicians currently licensed to practice medicine in North Carolina and all physician assistants and nurse practitioners currently licensed or approved to perform medical acts, tasks, and functions in this State.

(e) Applicants for positions on the Board shall not be required to be members of any professional association or society, except as provided in G.S. 90-2(a)(2)a."

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

HOUSE BILL 724

Short Title:	Amend Composition of NC Medical Board.	(Public)
Sponsors:	Representatives Lambeth, Malone, S. Martin, and Hurley (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 15, 2015

A BILL TO BE ENTITLED

AN ACT REVISING THE MEMBERSHIP OF THE NORTH CAROLINA MEDICAL BOARD TO ENSURE THAT AT LEAST ONE PHYSICIAN ASSISTANT AND AT LEAST ONE NURSE PRACTITIONER SERVE AS MEMBERS OF THE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-2(a) reads as rewritten:

"(a) There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of ~~12~~ 13 members.

(1) Seven of the members shall be duly licensed physicians recommended by the Review Panel and appointed by the Governor as set forth in G.S. 90-3.

(2) The remaining ~~five~~ six members shall all be appointed by the Governor as follows:

a. One shall be a duly licensed physician who is a doctor of osteopathy or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in that person's clinical practice or a member of The Old North State Medical Society. This Board position shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3.

b. Three shall be public members, and these Board positions shall not be subject to recommendations of the Review Panel pursuant to G.S. 90-3. A public member shall not be a health care provider nor the spouse of a health care provider. For the purpose of Board membership, "health care provider" means any licensed health care professional, agent or employee of a health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this section, a person enrolled in a program as preparation to be a licensed health care professional or an allied health professional shall be deemed a health care provider. For purposes of this section, any person with significant financial interest in a health service or profession is not a public member.

c. One shall be a physician assistant as defined in G.S. 90-18.1 ~~or a nurse practitioner as defined in G.S. 90-18.2~~ as recommended by the Review Panel pursuant to G.S. 90-3.

d. One shall be a nurse practitioner as defined in G.S. 90-18.2 as recommended by the Review Panel pursuant to G.S. 90-3."

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

HOUSE BILL 809:
Third-Party Premium Payments

2015-2016 General Assembly

Committee:	Senate Re-ref to Health Care. If fav, re-ref to Insurance	**Date:**	July 21, 2015
Introduced by:	Reps. Avila, Lewis, Collins, Setzer	**Prepared by:**	Kristen Harris
Analysis of:	Second Edition		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 809 would require that health benefit plans accept a premium payment made by the following third parties: The Ryan White HIV/AIDS program, Native American tribes or tribal organizations, State or federal government programs, and the American Kidney Fund.***

[As introduced, this bill was identical to S582, as introduced by Sen. Pate, which is currently in Senate Re-ref to Health Care. If fav, re-ref to Insurance.]

[The PCS only makes a technical correction.]

CURRENT LAW:

Federal law requires health insurance issuers offering qualified health plans (i.e. plans eligible to be sold on the health benefit exchanges) in the individual market to accept the premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs. 45 C.F.R. 156.1250

BILL ANALYSIS:

The Proposed Committee Substitute for House Bill 809 would add the American Kidney Fund to the list of entities from which a health benefit plan must accept a premium payment made on behalf of a plan enrollee. The federal law applies only to qualified health plans. House Bill 809 would apply to all health benefit plans regulated by Chapter 58 of the North Carolina General Statutes.

House Bill 809 would not require a health benefit plan to accept a third-party premium payment from a health care provider.

EFFECTIVE DATE: This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

Former Staff Attorney Amy Jo Johnson substantially contributed to this summary.

O. Walker Reagan
Director

H809-SMTU-59 E2 -V3

Research Division
(919) 733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 809*

Committee Substitute Favorable 4/22/15

PROPOSED SENATE COMMITTEE SUBSTITUTE H809-CSTU-23 [v.1]

7/17/2015 10:12:28 AM

Short Title: Third-Party Premium Payments. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO ALLOW THIRD-PARTY PREMIUM PAYMENTS FOR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-305. Third-party premium payments; refusal of acceptance.**

(a) A health benefit plan must accept a premium payment made by a third party to the insurance contract provided the payment is made from or pursuant to a fund or grant established by any of the following:

(1) The Ryan White HIV/AIDS program pursuant to Title XXVI of the Public Health Service Act.

(2) Native American tribes or tribal organizations.

(3) State or federal government programs.

(4) The American Kidney Fund.

(b) Nothing in this section shall be construed to require a health benefit plan to accept a third-party premium payment from a health care provider.

(c) As used in this section, "health benefit plan" is as defined in G.S. 58-3-167(a)(1)."

SECTION 2. This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 2

HOUSE BILL 809*
Committee Substitute Favorable 4/22/15

Short Title: Third-Party Premium Payments. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO ALLOW THIRD-PARTY PREMIUM PAYMENTS FOR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-305. Third-party premium payments; refusal of acceptance.**

(a) A health benefit plan must accept a premium payment made by a third party to the insurance contract provided the payment is made from or pursuant to a fund or grant established by any of the following:

(1) The Ryan White HIV/AIDS program pursuant to Title XXVI of the Public Health Service Act.

(2) Native American tribes or tribal organizations.

(3) State or federal government programs.

(4) The American Kidney Fund.

(b) Nothing in this section shall be construed to require a health benefit plan to accept a third-party premium payment for a health care provider.

(c) As used in this section, "health benefit plan" is as defined in G.S. 58-3-167(a)(1)."

SECTION 2. This act becomes effective October 1, 2015, and applies to health benefit contracts issued, renewed, or amended on or after that date.

Senate Pages Attending

COMMITTEE: Health Care ROOM: 544

DATE: 7-21 TIME: 11 AM

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

	Page Name	Hometown	Sponsoring Senator
1.	Anna Deutschle	Charlotte	Rucho
2.	Sam Stein	Raleigh	Stein
3.	Rees Massarelli	Raleigh	Stein
4.	Taylor Dozier	Raleigh	Stein
5.	Tristian Beard	Goldsboro	Sanderson / Pate
6.	Chax Cross	Denton	Sanderson / Bingham
7.	Endia Pullium	Durham	McKissick, Jr.
8.	Amber Avens	Roanoke Rapids	Bryant
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.

July 21, 2015

Senate Committee on Healthcare

Senate Sergeant–At-Arms

Dale Huff

Terry Barnhardt

Marcus Kitts

VISITOR REGISTRATION SHEET

Senate Health Committee
(Committee Name)

July 21, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sharon C. Wilder	Div. of Aging and Adult Services
Suzanne Merrill	DHHS/Div. of Aging & Adult Services
LaVarne Burton	American Kidney Fund
Courtney [illegible]	NP
Eric S Dolby SR	American Kidney Fund
Danielle Ward	
KEITH A. MENTE	FRESENIUS MEDICAL CARE
Dana Simpson	SA
Ben Popkin	NCDOI
TJ Bugbee	NP
Trent Womble	DHHS
JC Pennington	CSS
Joyce Peters	CSS
Elizabeth Schab	NCPHA
Sue Ann Forrest	NCICU
J Peters	CSS
[illegible]	NCDOI

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Committee
(Committee Name)

July 21, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Kimbrell	Parker Poe
Meg Miller	KCG
Skye David	KCG
Tom Freedman	SHP
Adam Sholar	DHHS
Lori Ann Harris	~~CAHA~~
Marty Bocock	Prime Therapeutics
Jon Lane	Jordan Price Law Firm
Mike Freeman	NCAE
Andy Keegan	NMRS
Cory Dixon	DRNC
Daniel VanLiere	Vidant Health
Mark Fleming	BCBSNC
Peyton Mayhew	

VISITOR REGISTRATION SHEET

Senate Health Committee
(Committee Name)

July 21, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elizabeth Meredith	NCMB
Olga Ivanushko	NCMB
Katherine Restrepo	John Locke Foundation
Belinda Asheth	NC DOT/DHHS Div of Aging
Zachary Richardson	
Chris McClure	BSP
Evelyn Hawthorne	ETOR
Sarah Preston	ACLU-NC
Annaliese Dolph	DL
Kay Castillo	NASW-NC
Adam Pridemore	NCASA
Douglas Hallbrook	NC SBA

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Committee
(Committee Name)

July 21, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Horaker	Troutman Sanders
ANDY WALSH	SA
Brenda Greenberg	NCSRT Inc.
Ashley Parkinson	Parkinson Law
Jay Singleton	Singleton Vision Center
Joanna Spruill	NCAFP
Jennifer Gasperini	NCMS
Sarah Bales	Brubaker & Assoc.
CADY THOMAS	Focus Carolina
Guy Glorioso	Carolinas HealthCare System
Martha Ann McConnell	Carolinas HealthCare System
Christine Cruz	WakeMed
Wendy Lecky	Focus Carolina
Lexi Morgan Arthur	NCRMA
MIKE JAMES	ACP
Bill Rustin	ACP
Peg O'Connell	Marsh & Dimes

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Committee
(Committee Name)

July 21, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Donna R. Clark	UNC Dept Gov
Elliot Engstrom	Civitas Institute
Felicia Hyde	Civitas Institute
Bob Luebke	" "
Duel G. Sheppard	Bill # 20
Tim Tetzlaff	FSP
Daniel Oxendine	Bill # 20
Sandra Chestnut	DHHS
Benjamin Kull	NC DOJ
Rachel E Badin	NCDPI
Sarah Wolfe	MWC
John Bode	B+H
Cathie Feild	NCAPA
Jonathan Barbakow	Barbakow + Assoc.
Brian Merwald	WM
Hayden Baugness	FSP
Joel Mayfield	GRA & ASSOC

Senate Committee on Health Care
Thursday, August 6, 2015 at 10:15 AM
643 Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:15 AM on August 6, 2015, in Room 643 of the Legislative Office Building. Sixteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by explaining that the meeting was starting later than the noticed time due to a meeting of the Senate Finance Committee where some members had been in attendance. He announced that session would begin at 11:30 AM to allow for the schedule shift. He then recognized the pages—Parker Castleberry, Cole Kukura, and Tyrek Rhodes of Wake County; Andrew Hartsfield of Wilson County; Ruth Woods of Johnston County; Emma Pardie of Davie County; Katie Sessoms of Rutherford County; and Rachel Stechschulte of Polk County. He then recognized the Sergeants-at-Arms—Giles Geffreys, Dale Huff, Ed Kesler, Hal Roach, and Matt Urben.

Senator Hise recognized Jennifer Hillman of the Research Division to present the PCS to the third edition of House Bill 372. Sen. Wade moved for consideration of the PCS for House Bill 372–2015 Medicaid Modernization. Ms. Hillman explained that the PCS had three substantive sections, and explained each section: first section—Medicaid transformation and reorganization; second section—the statewide health information exchange; third section—Medicaid primary care case management.

At the conclusion of Ms. Hillman's presentation, Senator Pate recognized Senator Hise for further explanation of the PCS. After commenting on the PCS, Senator Hise answered questions of Committee members. Senator Pate noted that the bill had a sequential referral to Appropriations/Base Budget for further discussion. Senator Tucker moved for a favorable report to the PCS, unfavorable to Committee Substitute #2, and also that staff be permitted to make technical changes to the PCS as necessary. The motion passed.

The meeting adjourned at 11:00 AM.

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Senator Louis Pate, Chair
Presiding

Senate Committee on Health Care
Thursday, August 6, 2015, 9:30 AM
544 Legislative Office Building

AGENDA

Senator Ralph Hise, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones

Adjournment

Susan Fanning (Sen. Ralph Hise)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Thursday, August 06, 2015 09:18 AM
To: Rep. Nelson Dollar; Rep. Bert Jones; Rep. Donny Lambeth; Rep. Brian Brown
Cc: Candace Slate (Rep. Nelson Dollar); Brenda Olls (Rep. Bert Jones); Pan Briles (Rep. Donny Lambeth); Theresa Lopez (Rep. Brian Brown)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Thursday, August 06, 2015 at 9:30 AM - CORRECTED #3
Attachments: Add Meeting to Calendar_LINC_.ics

Principal Clerk ____
Reading Clerk ____

Corrected #3: Time Change: Senate Health Care Committee to meet 10 minutes after conclusion of Senate Finance Committee

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Thursday	August 6, 2015	9:30 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones

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

Susan Fanning (Sen. Ralph Hise)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Thursday, August 06, 2015 09:03 AM
To: Rep. Nelson Dollar; Rep. Bert Jones; Rep. Donny Lambeth; Rep. Brian Brown
Cc: Candace Slate (Rep. Nelson Dollar); Brenda Olls (Rep. Bert Jones); Pan Briles (Rep. Donny Lambeth); Theresa Lopez (Rep. Brian Brown)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Thursday, August 06, 2015 at 9:30 AM - CORRECTED #2
Attachments: Add Meeting to Calendar_LINC_.ics

Principal Clerk ____
Reading Clerk ____

Corrected #2: Location has been changed to Room 643 LOB.

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Thursday	August 6, 2015	9:30 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones

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

Susan Fanning (Sen. Ralph Hise)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Wednesday, August 05, 2015 05:39 PM
To: Rep. Nelson Dollar; Rep. Bert Jones; Rep. Donny Lambeth; Rep. Brian Brown
Cc: Candace Slate (Rep. Nelson Dollar); Brenda Olls (Rep. Bert Jones); Pan Briles (Rep. Donny Lambeth); Theresa Lopez (Rep. Brian Brown)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Thursday, August 06, 2015 at 9:30 AM - CORRECTED #1
Attachments: Add Meeting to Calendar_LINC_.ics

Principal Clerk ____
Reading Clerk ____

Corrected #1: Location has been changed to Room 544 Legislative Office Building.

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Thursday	August 6, 2015	9:30 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones

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

Susan Fanning (Sen. Ralph Hise)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Wednesday, August 05, 2015 04:51 PM
To: Rep. Nelson Dollar; Rep. Bert Jones; Rep. Donny Lambeth; Rep. Brian Brown
Cc: Candace Slate (Rep. Nelson Dollar); Brenda Olls (Rep. Bert Jones); Pan Briles (Rep. Donny Lambeth); Theresa Lopez (Rep. Brian Brown)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Thursday, August 06, 2015 at 9:30 AM
Attachments: Add Meeting to Calendar_LINC_.ics

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
Thursday	August 6, 2015	9:30 AM	1027/1128 LB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 372	2015 Medicaid Modernization.	Representative Dollar Representative Lambeth Representative B. Brown Representative Jones

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

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Thursday, August 06, 2015

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

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

HB **372** **(CS#2)** 2015 Medicaid Modernization.

Draft Number:	H372-PCS20391-TR-4
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Ralph Hise will handle HB 372

HOUSE BILL 372
Committee Substitute Favorable 6/11/15
Committee Substitute #2 Favorable 6/18/15

Short Title: 2015 Medicaid Modernization. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE AND STABILIZE NORTH CAROLINA'S MEDICAID PROGRAM THROUGH PROVIDER-LED CAPITATED HEALTH PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.
(5) Improve health outcomes for the State's Medicaid population.

SECTION 2. Definitions. – As used in this act, the following terms have the following definitions:

(1) Capitation payment. – As defined in 42 C.F.R. 438.2.
(2) CMS. – The Centers for Medicare and Medicaid Services.
(3) Department. – The North Carolina Department of Health and Human Services.
(4) Provider. – As defined in G.S. 108C-2(10).
(5) Provider-led entity. – Any of the following:
    a. A provider.
    b. An entity with the primary purpose of owning or operating one or more providers.
    c. A business entity in which providers hold a controlling ownership interest.
(6) Recipient. – An individual who has been determined to be eligible for Medicaid or NC Health Choice.
(7) Secretary. – The Secretary of the Department.

SECTION 3. Structure of Delivery System. – The structure of the transformed Medicaid program required in Section 1 of this act shall be as follows:

(1) Provider-led entities shall implement full-risk capitated health plans to manage and coordinate the care for enough program aid categories to cover at least ninety percent (90%) of Medicaid recipients to be phased in over five years from the date this act becomes law. Program aid category coverage

shall not include dual eligibles for whom Medicaid pays only Medicare premiums. In aggregate, provider-led entities shall cover Medicaid recipients in all 100 counties.

(2) Provider-led entities ensure appropriate access to care for Medicaid recipients in all 100 counties while building upon the existing enhanced primary care medical home model.

(3) Provider-led entity contracts result in controlling the State's cost growth at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

(4) The Department implements a process for recipient assignment to provider-led entities. Assignment shall be based on the recipient's selection of a provider-led entity, or if the recipient fails to choose a provider-led entity during initial enrollment, the Department shall develop a process for auto-assignment to a provider-led entity. The Department may limit the circumstances under which a Medicaid recipient may change provider-led entity, including creating an open enrollment period.

(5) When fully implemented, the State retains only the risk of enrollment numbers and enrollment mix of the populations for which capitated payments are received.

(6) Capitated payments will be actuarially sound and risk-adjusted, based on the mix of enrollees by program aid category and other appropriate factors.

(7) The Department ensures administrative costs are minimized and establishes appropriate medical loss ratio for contractors accepting full-risk capitation, which allocates at least ninety percent (90%) of the capitated payments to cover patient care.

(8) The Department ensures contracts required under this act contain effective program integrity features to protect against provider fraud, waste, and abuse at all levels of the system.

(9) Provider-led entities will be responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, all claims processing, care management, case management, appeals, and all other necessary administrative services.

(10) A majority of each provider-led entity's governing board shall be comprised of physicians who treat Medicaid patients including those who provide clinical services to Medicaid patients.

SECTION 4. Time Line. – The following milestones for Medicaid transformation shall occur in the following order and relative time frame:

(1) Within 12 months of this act becoming law, the Department shall develop, with meaningful stakeholder engagement, and submit to CMS a request for a 1115 Medicaid demonstration waiver to implement the components of this act.

(2) Within 24 months of this act becoming law and with waiver approvals from CMS, the Department will issue an RFP for provider-led entities to bid on contracts required under this act.

(3) Within five years of the date this act becomes law, ninety percent (90%) of Medicaid recipients shall be enrolled in full-risk, capitated health plans for all services other than the services contracted for through the local management entities/managed care organizations (LME/MCOs), dental services and pharmaceutical products and dispensing fees. However, prior to reaching the coverage required under this subdivision, the Department may

accept a full-risk, capitated health plan as a pilot that begins within three years of enactment of this act.

(4) Within six years of the date this act becomes law, each provider-led entity under contract with the Department must meet the risk, cost, performance, and quality goals required by this act and as contained in the contract with the Department.

SECTION 5. Submission of Waiver. – The Department shall submit to CMS the 1115 waiver and any other waivers and State Plan amendments necessary to accomplish the requirements of this act within the required time frames.

SECTION 6. Components of RFP/Terms and Conditions of Contracts. – The following are mandatory components the Department must include in the RFP and in all contracts required under Section 3 of this act:

(1) No bid may be considered if it does not, at a minimum, provide for all of the following:
   a. Cover a defined population of at least 30,000 recipients.
   b. Ensure appropriate access to care for recipients.

(2) Individually, bidders must:
   a. Agree to receive risk-adjusted capitation rates for all health benefits and administrative services, including physical, long-term services and supports, and other medical services generally considered physical care.
   b. Agree to transition to full-risk capitation for all services and related administrative costs for enrolled populations within the three to five years following the enactment of this act.
   c. Agree to defined measures for risk-adjusted health outcomes, quality of care, patient satisfaction, and costs.
   d. Meet financial solvency requirements developed by the Department of Insurance that are equivalent to the solvency requirements for health maintenance organizations in G.S. 58-67-110.
   e. Assume responsibility for complying with appeal rights and program integrity functions.
   f. Meet all data systems standards.

(3) Collectively, bidders are responsible for:
   a. Coverage for all 100 counties.
   b. Managing ninety percent (90%) of the State's Medicaid population within five years of enactment. All dual eligibles shall be excluded.
   c. A reduction of at least two percentage (2%) points below the national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

(4) All contracts must:
   a. Include clear performance goals based on the defined measures that are monitored and measured at specified and appropriate intervals.
   b. Provide penalties for failure to meet the performance goals.
   c. Provide financial rewards for achieving performance goals.
   d. Be for a term of five years with options to renew or extend based upon successful performance, as determined by the Department and contained in the contract.
   e. Adhere to the quality standards that are developed by the Quality Assurance Advisory Committee and are consistent with State and national quality measures.

SECTION 7. DHHS to Lead. – The General Assembly delegates full authority to the Department of Health and Human Services to take all actions necessary to implement the Medicaid transformation described in this act. The Department shall administer and manage the program within the budget enacted by the General Assembly provided that the total expenditures, net of agency receipts, for the Medicaid program do not exceed the enacted budget. The Department shall employ or contract with individuals who have the appropriate experience and competencies to manage the State's Medicaid program in a predominantly contract environment. To ensure a successful program, the Department shall do all of the following:

(1) Establish procedures and criteria for certifying that contracts entered into under Section 6 of this act establish an adequate medical services delivery network, including determining criteria to ensure Medicaid recipients have access to all medically necessary services.

(2) Establish quality standards and minimum services delivery network requirements for contracts entered into under Section 6 of this act.

(3) Ensure recipients have appropriate access to primary care and specialty care services and shall develop a rate floor for this purpose.

(4) Establish and implement quality assurance measures for the contracts entered into under Section 6 of this act.

(5) Adopt and implement requirements for the contracts entered into under Section 6 of this act concerning Health Information Technology, robust data analytics, quality of care, and care-quality improvement.

(6) Ensure that providers are required to manage care under appropriate evidence-based standards of care to more efficiently manage utilization and clinical resources.

(7) Encourage providers to utilize appropriate technologies, such as telemedicine, to provide expeditious care and ensure access to services.

(8) Establish procedures for termination of a contract entered into under Section 6 of this act for nonperformance of contractual duty or failure to meet or maintain benchmarks, standards, or requirements provided by this act or established by the Department.

SECTION 8. Quality Assurance Advisory Committee. – The Secretary shall convene an advisory committee consisting of experts in the areas of Medicaid, actuarial science, health economics, health benefits, health quality outcomes, and administration of health law and policy. At least one shall be a member of the North Carolina State Health Coordinating Council.

The Committee shall advise the Department on the development and submission of requests for all federal waivers that are necessary to implement this act and to support the development and approval of the performance goals that will serve as the basis of the pay-for-performance system. The committee shall terminate five years from the date of enactment of this act.

SECTION 9. Audits of Plans. – The Department shall contract for periodic financial audits of each successful bidder based on the terms and conditions of the awarded contract.

SECTION 10.(a) Maintain Funding Mechanisms. – The Department shall work with CMS to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the greatest extent possible. If such Medicaid-specific funding cannot be maintained, then the Department shall advise the Joint Legislative Oversight Committee created in Section 11 of this act of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation.

SECTION 10.(b) Maintain Existing 1915 (b)/(c) Waiver. – The Department shall continue implementation of the existing 1915 (b)/(c) waiver.

SECTION 11.(a) Legislative Oversight of Medicaid. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid.**

(a) The Joint Legislative Oversight Committee on Medicaid is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-209.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on Medicaid shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to the Department of Health and Human Services.

(b) The Committee shall make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

"**§ 120-209.2. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on Medicaid, while in discharge of official duties, shall have access to any paper or document and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee.

"**§ 120-209.4. Reports to Committee.**

Whenever the Department is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters affecting the

Medicaid or NC Health Choice programs, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Medicaid."

SECTION 11.(b) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 12. Appropriation. – To accomplish the Medicaid transformation required by this act, there is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of two million five hundred thousand dollars ($2,500,000) in nonrecurring funds for the 2015-2016 and the 2016-2017 fiscal years. These funds shall provide a State match for an estimated two million five hundred thousand dollars ($2,500,000) in federal funds beginning in the 2015-2016 fiscal year, and those federal funds are hereby appropriated to the Division of Medical Assistance to pay for Medicaid transformation.

SECTION 13. Section 12 of this act becomes effective upon appropriation by the General Assembly of funds for the implementation of this act. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 372
Committee Substitute Favorable 6/11/15
Committee Substitute #2 Favorable 6/18/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H372-CSTR-4 [v.7]

Short Title: Medicaid Transformation/HIE/PrimaryCare/Funds. (Public)

Sponsors:

Referred to:

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO TRANSFORM AND REORGANIZE NORTH CAROLINA'S MEDICAID AND NC HEALTH CHOICE PROGRAMS, TO PROVIDE FUNDS FOR THE OVERSIGHT AND ADMINISTRATION OF THE STATEWIDE HEALTH INFORMATION EXCHANGE NETWORK, TO INCREASE MEDICAID RATES TO PRIMARY CARE PHYSICIANS, AND TO DISCONTINUE MEDICAID PRIMARY CARE CASE MANAGEMENT.

The General Assembly of North Carolina enacts:

MEDICAID TRANSFORMATION AND REORGANIZATION

SECTION 1.(a) Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.

SECTION 1.(b) Structure of Delivery System. – The transformed Medicaid program described in subsection (a) of this section shall be organized according to the following principles and parameters:

(1) The Department of Medicaid (DOM), created in subsection (h) of this section, shall have full budget and regulatory authority to manage the State's Medicaid and NC Health Choice programs, except the General Assembly shall determine eligibility categories and income thresholds.
(2) Among its initial tasks, the DOM shall:
    a. Determine the structural and financial qualifications required for Medicaid managed care organizations (MCOs), which is defined to include both commercial insurers and provider-led entities (PLEs). A PLE is defined as any of the following: a provider; an entity with the primary purpose of owning or operating one or more providers; or a business entity in which providers hold a controlling ownership interest. The majority of the members of a PLE's governing board

shall be composed of providers as defined in G.S. 108C-2 or entities composed of providers.

b. Designate at least five and no more than eight regions within the State. Regions must be composed of whole, contiguous counties, and every county in the State must be assigned to a region.

(3) The DOM shall enter into contractual relationships with commercial insurers and PLEs for the delivery of all Medicaid health care items and services. All contracts shall be the result of a request for proposals (RFP) issued by the DOM and the submission of competitive bids by commercial insurers and PLEs. The governing principles and minimum terms and conditions of the RFPs, bids, and contracts are described in subsection (d) of this section.

(4) The number and nature of the contracts required under subdivision (3) of this subsection shall be as follows:

a. Three contracts between the DOM and any combination of individual commercial insurers and individual PLEs. Each of these contracts shall provide statewide coverage for all Medicaid health care items and services (statewide contracts).

b. Up to 12 contracts between the DOM and individual PLEs for coverage of specified regions (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for all Medicaid health care items and services. A PLE may bid on more than one region. The DOM shall have full discretion to enter into one, two, or no regional contracts in any region.

(5) As a result of the contracts entered into by the DOM under subdivision (3) of this subsection, a recipient shall have at least three, but no more than five enrollment choices for the provision of all Medicaid health care items and services. The DOM shall provide for annual open enrollment periods and shall determine the process for assigning recipients who do not select a commercial insurer or PLE during the enrollment period.

SECTION 1.(c) Time Line. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. -

a. The Department of Medicaid is created pursuant to subsection (h) of this section.

b. The Joint Legislative Oversight Committee on Medicaid (LOC on Medicaid) is created pursuant to subsection (l) of this section to oversee the Medicaid and NC Health Choice programs.

(2) December 1, 2015. – The Department of Health and Human Services (DHHS) shall establish the Medicaid stabilization team pursuant to subsection (g) of this section.

(3) January 1, 2016. –

a. The DOM is designated as the single State agency for the administration of Medicaid and NC Health Choice.

b. The DHHS and the DOM shall enter into agreements necessary for the DOM to supervise the DHHS's administration of the Medicaid and NC Health Choice programs.

(4) May 1, 2016. –

a. The DOM shall submit requests for waivers and State Plan amendments to the Centers for Medicare and Medicaid Services (CMS) necessary to implement Medicaid transformation.

b. The DOM shall report recommended statutory changes to the North Carolina General Statutes to the LOC on Medicaic.

(5) Twelve months after CMS approval of all necessary waivers and State Plan amendments. – Capitated full-risk contracts begin.

SECTION 1.(d) Requests for Proposals; Bids; Terms and Conditions of Contracts. – The following shall be components of the initial RFPs, responsive bids to the initial RFPs, and the initial contracts that are required under subsection (b) of this section.

(1) An RFP may solicit bids for a statewide contract, a regional contract, or both, and may propose variable contract durations.

(2) RFPs must require at least all of the following:

a. Full-risk capitation for all Medicaid health care items and services.

b. Coverage for all program aid categories except the dual eligible categories.

c. All bidders meet solvency requirements established by the Department of Insurance pursuant to subsection (k1) of this section.

d. All bidders meet the same standards and metrics for risk, outcomes, and quality.

e. All bidders establish appropriate networks or providers to deliver services.

f. All bidders subcontract with existing LME/MCOs for behavioral health services through the end date of the first contract entered into pursuant to this section at a capitation rate that is no less than the most recently negotiated rate for the then current scope of benefits paid to LME/MCOs.

g. All bidders agree not to limit providers' ability to contract with other commercial insurers and PLEs.

h. All bidders must connect to the Health Information Exchange Network or any successor information technology entity or architecture specified by the DOM in order to ensure effective systems and connectivity to support clinical coordination of care, exchange of information, and the availability of data to the DOM to manage the Medicaid and NC Health Choice program for the State.

i. All bidders ensure that their contracts with providers include value-based payment systems that support the achievement of overall performance, quality, and outcome measures.

(3) All bids must respond to the requirements of subdivision (2) of this subsection and must also include at least all of the following:

a. For statewide contracts, a description of how the commercial insurer or PLE will ensure access to appropriate care throughout the State.

b. For regional contracts, a description of how the PLE will ensure access to appropriate care throughout the region.

c. Proposed competitive medical loss ratios.

d. Proposed full-risk capitated rates based on Centers for Medicare and Medicaid Services (CMS) actuarial soundness and industry standards as well as risk-adjusted rate ranges using claims data from fiscal year 2014-2015. Actuarial calculations must include utilization assumptions consistent with industry and local standards.

e. Methods to ensure program integrity against provider fraud, waste, and abuse at all levels.

(4) In addition to the requirements of subdivisions (1) through (3) of this subsection, each contract must provide for all of the following:

a. Negotiated full-risk capitated rates, including a portion that is at risk for achievement of quality and outcome measures.

b. Negotiated competitive medical loss ratios.

c. Compliance by the commercial insurer or PLE with all CMS requirements for the Medicaid and NC Health Choice programs.

d. Defined measures and goals for risk adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component must be measured and monitored continually and reported at set intervals as determined by the DOM. Each component shall be subject to specific accountability measures, including penalties. The DOM may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), Healthcare Effectiveness Data and Information Set (HEDIS), or any others necessary to develop effective measures for outcomes and quality.

e. Acceptance of full responsibility by the commercial insurer or PLE for all grievance and appeals.

f. Ability of the commercial insurer or PLE to exclude providers from networks based on economic or quality standards.

g. Ability of the commercial insurer or PLE to terminate the capitation rate required under sub-subdivision f. of subdivision (2) of this subsection if termination of the rate is mutually agreed to by the LME/MCO.

h. Agreement that covered benefits will not be reduced from the covered services in effect on the date the contract is awarded except in instances where the DOM reduces a covered service for all recipients and for all contracts.

i. A rate floor for primary care and specialty care services set by the DOM to ensure recipients have appropriate access to these services.

j. Agreement that the commercial insurer or PLE will pay LME/MCOs the capitation rate required by sub-subdivision f. of subdivision (2) of this subsection within 30 days after the commercial insurer or PLE receives funds for the capitation from the DOM.

k. A requirement that the commercial insurer or PLE must keep the cost growth for its enrollees at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

l. A requirement that the commercial insurer or PLE participate in the existing preferred drug list program maintained by DHHS as required by Section 10.66 of S.L. 2009-451 and maximize the recovery and collection of drug rebates.

SECTION 1.(e) Monthly Progress Report. – Beginning February 1, 2016, and monthly thereafter until January 1, 2019, the DOM shall report to the LOC on Medicaid and the Fiscal Research Division on the State's progress toward completing Medicaid transformation. The May 1, 2016, report shall contain proposed changes to the North Carolina General Statutes that are necessary to implement Medicaid transformation.

SECTION 1.(f) Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this section, the DOM shall work with the Centers for Medicare and Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then the DOM shall advise the LOC on Medicaid created in subsection (l) of this section of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

SECTION 1.(g) DHHS Role in Medicaid Transformation. – During Medicaid transformation, the Department of Health and Human Services, Division of Medical Assistance (DMA), shall cooperate with the DOM to ensure a smooth transition of the Medicaid and NC Health Choice programs and shall perform all of the following functions:

(1) The DHHS and the DOM shall enter into agreements necessary for the DOM to supervise the DHHS's administration of the Medicaid and NC Health Choice programs until the transformed Medicaid program is completed.

(2) The Department of Health and Human Services, Office of the Secretary, (Office of the Secretary) shall organize a Medicaid stabilization team to do the following:

a. Maintain the Medicaid and NC Health Choice programs until Medicaid transformation has been completed.

b. Work with the DOM during the transition.

c. Develop strategies to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.

d. Make recommendations to the LOC on Medicaid on any additional authorization or funding necessary to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.

e. With assistance from the Office of State Human Resources, conduct interviews and meetings with designated essential employees of the DMA to explain the transition process, including options for the employees and the bonus payment system established under this subsection.

f. No later than December 1, 2015, report to the LOC on Medicaid on the plan to communicate to employees, as required by sub-subdivision e. of this subdivision.

(3) The Office of the Secretary shall identify the key managers, leaders, and decision makers to be part of the stabilization team and, no later than December 1, 2015, shall submit a list of these people and their roles to the DOM and the LOC on Medicaid.

(4) No later than December 1, 2015, the Secretary of Health and Human Services (Secretary) shall identify and designate "essential positions" throughout the DHHS without which the Medicaid and NC Health Choice programs could not operate on a day-to-day basis. Such positions designated by the Secretary may include any position, whether subject to or exempt from the North Carolina Human Resources Act or whether supervisory or nonsupervisory, as long as the position is essential to the operation of Medicaid or NC Health Choice. Because the designation is based on the functions to be performed and because of the nature of the bonuses provided

under this subsection, the designation of a position as essential may not be revoked, and the Secretary may designate both open and filled positions.

(5) In order to encourage employees to remain in their positions working on Medicaid and NC Health Choice within the DHHS, employees serving in positions designated as essential positions under this subsection shall be eligible for the following benefits:

a. Effective November 1, 2015, any employee working in a designated essential position within the DMA shall receive a bonus at each pay period that is equal to five percent (5%) of the employee's earnings for that period.

b. Effective November 1, 2015, any employee working in a designated essential position within the DHHS, but outside of the DMA, whose salary is paid with federal Medicaid funds shall also receive a five percent (5%) bonus, paid in the same manner as bonuses are paid under sub-subdivision a. of this subdivision. If such an employee working outside of the DMA does not work full-time on Medicaid issues, then the amount of the bonus shall be calculated by first multiplying the employee's earnings for that period by the percentage of the employee's time spent on Medicaid issues and then multiplying that product by five percent (5%).

c. Any employee who received bonus payments under sub-subdivisions a. or b. of this subdivision who is still employed within the DMA or within the DHHS as of October 31, 2017, or who is employed within the DOM, shall receive a final bonus payment equal to the sum of all the bonus payments that the employee had received since November 1, 2015, under sub-subdivision a. of this subdivision. No employee departing before October 31, 2017, shall be eligible to receive any portion of such a final bonus payment, and no property right is created by this subsection for employees that depart before October 31, 2017.

d. The bonus payments paid under this subsection are made notwithstanding G.S. 126-4(2) or any other provision of law. Notwithstanding G.S. 135-1(7a), bonus payments paid under this subsection shall not count as "compensation" for purposes of the Retirement System for Teachers and State Employees, nor shall the DHHS be required to make payments to the Retirement System based on the amounts paid as bonuses. Additionally, bonus payments paid under this subsection shall not count as "compensation" or "salary" for calculating severance payments under G.S. 126-8.5 or calculating unemployment benefits.

(6) The DHHS shall not enter into any new contracts, or renew or extend any contracts that existed prior to the effective date of this subsection, related to the Medicaid or NC Health Choice programs without the express prior approval of the DOM. The DHHS and the DMA shall ensure that any Medicaid-related or NC Health Choice-related State contract entered into after the effective date of this act contains a clause that allows the DHHS or the DMA to terminate the contract without cause upon 30 days' notice. Any contract signed by the DHHS or the DMA after the effective date of this act that lacks such a termination clause shall, nonetheless, be deemed to include such a clause and shall be cancellable without cause upon 30 days' notice.

SECTION 1.(h) The Department of Medicaid is established as a new executive department. In accordance with the time line set out in subsection (c) of this section, the Department of Medicaid shall administer and operation all functions, powers, duties, obligations, and services related to the Medicaid and NC Health Choice programs. In accordance with the time line set out in subsection (c) of this section, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Department of Medicaid.

SECTION 1.(i) Chapter 143B of the General Statutes is amended by adding a new Article to read:

"Article 14.

"Department of Medicaid

"**§ 143B-1400. Creation and organization.**

(a) There is hereby established the Department of Medicaid (Department) to administer and operate the Medicaid and NC Health Choice programs. The head of the Department of Medicaid is the Secretary of the Department of Medicaid, who shall be known as the Secretary. The Department shall be the designated single State agency for the administration and operation of the Medicaid and NC Health Choice programs.

(b) The Secretary shall be appointed by the Governor subject to confirmation by the General Assembly by joint resolution, which shall originate in the House of Representatives. The Secretary shall be subject to removal by the Governor.

(c) The powers and duties of the deputy secretaries and the divisions and directors of the Department shall be subject to the direction and control of the Secretary.

"**§ 143B-1405. Powers and duties of the Secretary of Medicaid.**

(a) The Secretary of the Department of Medicaid shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Appoint all employees, including consultants and legal counsel, necessary to carry out the powers and duties of the office. In hiring staff, the Secretary may offer employment contracts for a term and set compensation for the employees, including performance-based bonuses based on meeting budget or other targets.

(3) Procure office space for the Department.

(4) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(5) Employ or contract for independent internal auditing staff.

(6) Pursuant to G.S. 108A-1, supervise the county departments of social services in their administration of eligibility determinations. Pursuant to subdivision (5) of this subsection, the Secretary may enter into a Memorandum of Understanding with the Department of Health and Human Services or contract with any other appropriate party to perform this task or a portion of this task.

(7) Define and implement the following for the Medicaid and Health Choice programs and any other programs administered by the Department:

a. Business policy.

b. Strategic plans, including desired health outcomes for the covered populations, which shall do the following:

1. Be developed at a frequency of no less than every five years with the input of stakeholders.
2. Identify key opportunities and challenges facing the organization.
3. Identify the Department's strengths and weaknesses to address these opportunities and challenges.
4. Identify key goals for the Department for this time period, consistent with the reform goals identified by the General Assembly.
5. Identify output and outcome performance measures to quantify the Department's progress toward these goals.
6. Identify strategies to reach these goals.
7. Be used as a guide for units within the Department to establish unit-specific operational plans at the same frequency.

c. Performance management system, including quantitative indicators for goals and objectives, which shall do the following:

1. Be developed and implemented within the first year of the creation of the Department, and updated no less than annually thereafter with available data.
2. Establish quantitative performance measures focusing on the quality and efficiency of service delivery and administration, using a nationally recognized quality improvement effort allowing comparison of North Carolina to other states as those developed by, but not limited to, the federal Medicaid Quality Measurement Program and the Baldridge Quality Program.
3. Establish measurable objectives for each goal identified in the strategic plan, and performance updated annually.
4. Establish, for each objective, benchmark activities, including an estimated date of completion, the area for which efforts are attempting a change, a quantitative indicator of success for the area, and quarterly milestones allowing Department managers and employees to monitor progress throughout the year.
5. Establish mechanisms for obtaining data necessary for the collection and public distribution of performance information.

d. Program and policy changes.

e. Operational budget and assumptions.

(8) Establish and adjust all program components, except for eligibility, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.

(9) Adopt rules related to the Medicaid and NC Health Choice programs.

(10) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(11) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(12) Develop and present to the Joint Legislative Oversight Committee on Medicaid and the Office of State Budget and Management by January 1 of

each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(13) Secure and pay for the services of the State Auditor's Office to conduct annual audits of the financial accounts of the Department.

(14) Publish the Annual Medicaid Report, which shall contain, at a minimum, the following:

a. Details on the Department's performance over the prior four years on the following:

1. The identified quantitative measures from its strategic plan and performance management system.

2. A comparison of the identified quantitative measures from its strategic plan and performance management system and other states participating in the quality improvement effort.

b. Annual audited financial statements.

(15) Publish in an electronic format, and update on at least a monthly basis, at least the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(b) Pursuant to G.S. 108E-2-1, the General Assembly retains the authority to determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs.

"**§ 143B-1410. Variations from certain State laws.**

Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Department of Medicaid and the Secretary of the Department of Medicaid, notwithstanding any other provision of law:

(1) Employees of the Department shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Department's employment contracts offered pursuant to G.S. 143B-1405 (a)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Department is exempt from State contract review and approval requirements, but may still choose to utilize the State contract review and approval procedures for particular contracts.

"**§ 143B-216.1415. Cooling off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Medicaid shall not contract for goods or services with a vendor that employs or contracts with a person who is a

former Medicaid or NC Health Choice employee and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former Medicaid or NC Health Choice employee in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section. Any person who submits a certification required by this subsection knowing the certification to be false shall be guilty of a Class I felony.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – Oversight of the performance of a contract, authority to make decisions regarding a contract, interpretation of a contract, or participation in the development of specifications or terms of a contract or in the preparation or award of a contract.

(2) Former Medicaid or NC Health Choice employee. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department, who in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.

"**§ 143B-216.1420. Medicaid Reserve Account.**

(a) The Medicaid Reserve Account is established as a nonreverting reserve in the General Fund. The purpose of the Medicaid Reserve Account is to provide for unexpected budgetary shortfalls within the Medicaid and NC Health Choice programs that result from program expenditures in excess of the amount appropriated for the Medicaid and NC Health Choice programs by the General Assembly and which continue to exist after the Health Benefits Authority makes its best efforts to control costs through midyear budget corrections under G.S. 143B-1410(a)(10).

(b) The Medicaid Reserve Account shall have the following minimum and maximum target balances:

(1) Minimum target. – Five percent (5%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(2) Maximum target. – Twelve percent (12%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(c) Notwithstanding G.S. 143C-1-2(b), any funds appropriated to the Department for the Medicaid or NC Health Choice programs and that remain unencumbered at the end of a fiscal year shall, rather than revert to the General Fund, be credited to the Medicaid Reserve Account. Any funds to be deposited in the Medicaid Reserve Account that would cause the fund balance to exceed the maximum target balance for the Medicaid Reserve Account shall instead be credited to the General Fund.

(d) Medicaid Reserve Account funds may be disbursed by the Secretary to manage budgetary shortfalls in the Medicaid and NC Health Choice programs only after all of the following occur:

(1) The Secretary certifies that there is a projected Medicaid shortfall in the current fiscal year.

(2) The Secretary has already made midyear budget corrections under G.S. 143B-1410(a)(10), but those midyear budget corrections have not achieved the projected budget savings.

(3) The Secretary reports to the Joint Legislative Commission on Governmental Operations on its intent to disburse Medicaid Reserve Account funds. The

report shall include a detailed analysis of receipts, payments, claims, and transfers, including an identification of and explanation of the recurring and nonrecurring components of the shortfall.

(e) Medicaid Reserve Account funds may be disbursed in accordance with subsection (d) of this section even if it results in the fund balance falling below the minimum target balance for the Medicaid Reserve Account."

SECTION 1.(j) Transfer of Rules. – Effective January 1, 2016, all rules and policies exempted from rule making related to the Medicaid and NC Health Choice programs shall transfer to the Department of Medicaid. In its May 1, 2016, report to the Joint Legislative Oversight Committee on Medicaid, the Department shall include recommendations for additional exemptions from the rule-making requirements and contested case provisions in Chapter 150B of the General Statutes.

SECTION 1.(k) Legal Actions. – For any legal action involving the Medicaid or NC Health Choice programs in which the Division of Medical Assistance or the Department of Health and Human Services is named as a party, the Department of Medicaid may be joined as a party by reason of transfer of interest upon motion of any party pursuant to Rule 25(d) of the North Carolina Rules of Civil Procedure. This subsection shall not be construed to limit any other opportunities for joinder or intervention that are otherwise allowed under the North Carolina Rules of Civil Procedure or elsewhere under law.

SECTION 1.(k1) The Commissioner of Insurance shall establish solvency requirements for MCOs and PLEs that contract with the Department pursuant to this section. The same requirements shall apply to and may be based on existing requirements for similarly situated regulated entities. The Commissioner shall consult with the Secretary of the Department of Medicaid in developing the requirements. The Commissioner shall make recommendations, including any statutory changes, to the Joint Legislative Oversight Committee on Medicaid by May 1, 2016.

SECTION 1.(l) Legislative Oversight of Medicaid. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on Medicaid.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on Medicaid.**

(a) The Joint Legislative Oversight Committee on Medicaid is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year except initial appointments begin on the date of appointment. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-209.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on Medicaid shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to the Department of Medicaid.

(b) The Committee may make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

"**§ 120-209.2. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Medicaid. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on Medicaid, while in discharge of official duties, shall have access to any paper or document, and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly.

"**§ 120-209.4. Reports to Committee.**

Whenever the Department of Medicaid is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Department."

SECTION 1.(m) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 1.(n) Recodification; Technical and Conforming Changes. – The Revisor of Statutes shall recodify existing law related to Medicaid and NC Health Choice, including Parts 6, 6A, 7, and 8 of Article 2, Article 5, and Article 7 of Chapter 108A of the General Statutes, as well as Chapters 108C and 108D of the General Statutes, into a new Chapter 108E of the General Statutes to be entitled "Medicaid and NC Health Choice Health Benefit Programs" and to have the following structure:

Article 1. Administration of the Medicaid and NC Health Choice Programs
- Part 1. Establishment of the Medicaid Program
- Part 2. Establishment of the NC Health Choice Program
- Part 3. Administration by County Departments of Social Services

Article 2. Medicaid and NC Health Choice Eligibility
- Part 1. In General
- Part 2. Eligibility for Medicaid
- Part 3. Eligibility for NC Health Choice

Article 3. Medicaid and NC Health Choice Benefits and Cost-Sharing
- Part 1. In General
- Part 2. Medicaid Benefits and Cost-Sharing
- Part 3. NC Health Choice Benefits and Cost-Sharing

Article 4. Medicaid and NC Health Choice Provider Requirements
- Part 1. Provider Enrollment
- Part 2. Provider Reimbursement and Recovery
- Part 3. Hospital Assessment Act

Part 4. Other
Article 5. Third-Party Liability
Part 1. In General
Part 2. Subrogation
Part 3. Insurance
Part 4. Estate Recovery
Article 6. Fraud and Criminal Activity
Article 7. Appeals
Part 1. Eligibility Appeals for Medicaid and NC Health Choice
Part 2. Benefit Appeals for Medicaid
Subpart 1. Generally
Subpart 2. Medicaid Managed Care for Behavioral Health Services Appeals
Part 3. Benefit Reviews for NC Health Choice
Part 4. Provider Appeals

When recodifying, the Revisor is authorized to change all references to the North Carolina Department of Health and Human Services or to the Division of Medical Assistance to instead be references to the Department of Medicaid and references to the Secretary of the Department of Health and Human Services to the Secretary of the Department of Medicaid. The Revisor may separate subsections of existing statutory sections into new sections and, when necessary to organize relevant law into its proper place in the above structure, may rearrange sentences that currently appear within subsections. The Revisor may modify statutory citations throughout the General Statutes, as appropriate, and may modify any references to statutory Divisions, such as "Chapter," "Article," "Part," "section," or "subsection." Within Articles 4 and 5 of Chapter 108A of the General Statutes, the Revisor of Statutes shall append to each reference to the North Carolina Department of Health and Human Services or to the Secretary of the Department the language "and, with respect to Medicaid and NC Health Choice, the Department of Medicaid." The Revisor of Statutes may conform names and titles changed by this subsection, and may correct statutory references as required by this subsection, throughout the General Statutes. In making the changes authorized by this subsection, the Revisor may also adjust subject and verb agreement and the placement of conjunctions. The Revisor shall consult with the Department of Health and Human Services and the Department of Medicaid on this recodification.

SECTION 1.(o) G.S. 108A-1 reads as rewritten:

"**§ 108A-1. Creation.**

Every county shall have a board of social services or a consolidated human services board created pursuant to G.S. 153A-77(b) which shall establish county policies for the programs established by this Chapter in conformity with the rules and regulations of the Social Services Commission and under the supervision of the Department of Health and Human Services. Provided, however, county policies for the program of medical assistance shall be established in conformity with the rules and regulations of the ~~Department of Health and Human Services~~Department of Medicaid"

SECTION 1.(p) G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) ~~No provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.~~The Department of Medicaid is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget.

~~(b) The Department may submit amendments to the State Plan only as required under any of the following circumstances:~~

~~(1) A law enacted by the General Assembly directs the Department to submit an amendment to the State Plan.~~

~~(2) A law enacted by the General Assembly makes a change to the Medicaid Program that requires approval by the federal government.~~

~~(3) A change in federal law, including regulatory law, or a change in the interpretation of federal law by the federal government requires an amendment to the State Plan.~~

~~(4) A change made by the Department to the Medicaid Program requires an amendment to the State Plan, if the change was within the authority granted to the Department by State law.~~

~~(5) An amendment to the State Plan is required in response to an order of a court of competent jurisdiction.~~

~~(6) An amendment to the State Plan is required to ensure continued federal financial participation.~~

~~(c) Amendments to the State Plan submitted to the federal government for approval shall contain only those changes that are allowed by the authority for submitting an amendment to the State Plan in subsection (b) of this section.~~

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the amendment has been posted. This requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. ~~The amendment shall remain posted on the Department's Web site at least until the plan has been approved, rejected, or withdrawn. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.~~

~~(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section. Additionally, if a change is made to the Medicaid program by the General Assembly and that change requires an amendment to the State Plan, then the amendment shall be submitted at least 90 days prior to the effective date of the change as provided in the legislation.~~

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 1.(q) G.S. 108A-54.2(d) is repealed.

SECTION 1.(r) Part 1 of Article 2 of Chapter 108E of the General Statutes, created by the recodification process described in subsection (n) of this section, shall include the following two new sections:

"**§ 108E-2-1. General Assembly sets eligibility categories.**

Eligibility categories and income thresholds are set by the General Assembly, and the Department of Medicaid shall not alter the eligibility categories and income thresholds from

those authorized by the General Assembly. The Department is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with parameters set by the General Assembly.

"**§ 108E-2-2. Counties determine eligibility.**

Counties determine eligibility in accordance with Chapter 108A of the General Statutes."

SECTION 1.(s) G.S. 126-5 is amended by adding a new subdivision to read:

"**§ 126-5. Employees subject to Chapter; exemptions.**

...

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

...

(31) Employees of the Department of Medicaid."

SECTION 1.(t) G.S. 143B-153 reads as rewritten:

"**§ 143B-153. Social Services Commission – creation, powers and duties.**

There is hereby created the Social Services Commission of the Department of Health and Human Services with the power and duty to adopt rules and regulations to be followed in the conduct of the State's social service programs with the power and duty to adopt, amend, and rescind rules and regulations under and not inconsistent with the laws of the State necessary to carry out the provisions and purposes of this Article. Provided, however, the ~~Department of Health and Human Services~~Department of Medicaid shall have the power and duty to adopt rules and regulations to be followed in the conduct of the State's medical assistance program.

...."

SECTION 1.(u) G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(d) Exemptions from Rule Making. – Article 2A of this Chapter does not apply to the following:

...

(9) The ~~Department of Health and Human Services~~ Department of Medicaid in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice programs pursuant to G.S. 108A-54.2.

...

(20) The ~~Department of Health and Human Services~~ Department of Medicaid in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs.

...

(22) The ~~Department of Health and Human Services~~ Department of Medicaid with respect to the content of State Plans, State Plan Amendments, and Waivers approved by the Centers for Medicare and Medicaid Services (CMS) for the North Carolina Medicaid Program and the NC Health Choice program.

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The ~~Department of Health and Human Services~~ Department of Medicaid with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination

of health services, in whole or in part, including a determination about the type or level of services.

...."

SECTION 1.(v) Appropriation. – The sum of five million dollars ($5,000,000) in recurring funds for the 2015-2016 and the 2016-2017 fiscal years are appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, to accomplish the Medicaid transformation required by this section. These funds shall provide a State match for an estimated five million dollars ($5,000,000) in federal funds beginning in the 2015-2016 fiscal year. Upon request of the Department of Medicaid, but no later than January 1, 2016, the Department shall transfer these funds to the Department of Medicaid to be used for Medicaid transformation.

SECTION 1.(w) Effective Date. – Subsections (n) through (u) of this section become effective January 1, 2016. The remainder of this section is effective when this act becomes law.

FUNDS FOR OVERSIGHT AND ADMINISTRATION OF STATEWIDE HEALTH INFORMATION EXCHANGE NETWORK

SECTION 2.(a) It is the intent of the General Assembly to do all of the following with respect to health information exchange:

(1) Establish a successor HIE Network to which (i) all Medicaid providers shall be connected by October 1, 2017, and (ii) all other entities that receive State funds for the provision of health services shall be connected by January 1, 2018.

(2) Establish (i) a State-controlled Health Information Exchange Authority to oversee and administer the successor HIE Network and (ii) a Health Information Exchange Advisory Board to provide consultation to the Authority on matters pertaining to administration and operation of the HIE Network and on statewide health information exchange, generally.

(3) Have the successor HIE Network gradually become and remain one hundred percent (100%) receipt-supported by establishing reasonable participation fees approved by the General Assembly and by drawing down available matching funds whenever possible.

SECTION 2.(b) In order to achieve the objectives described in subsection (a) of this section, the sum of eight million dollars ($8,000,000) in recurring funds for the 2015-2016 and the 2016-2017 fiscal years are appropriated to the Department of Health and Human Services, Division of Central Management and Support, for the 2015-2016 fiscal year and for the 2016-2017 fiscal year to continue efforts toward the implementation of a statewide health information exchange network shall be transferred to the Department of Information Technology. By 30 days after the effective date of this section, the Secretary of the Department of Health and Human Services and the State Chief Information Officer (State CIO) shall enter into a written memorandum of understanding pursuant to which the State CIO will have sole authority to direct the expenditure of these funds until (i) the North Carolina Health Information Exchange Authority (Authority) is established and the State CIO has appointed an Authority Director, and (ii) the North Carolina Health Information Exchange Advisory Board (Advisory Board) is established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The State CIO shall use these transferred funds to accomplish the following:

(1) Beginning immediately upon receipt of the transferred funds, facilitate the following:

a. Establishment of the successor HIE Network described in subsection (a) of this section.

b. Termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(2) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred seventy-seven thousand dollars ($177,000) per month, or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The State CIO shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The State CIO is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 2.(c) Once the Authority Director has been hired and the Advisory Board has been established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section, the Authority shall use these funds to do the following:

(1) Fund the operational expenses of the Authority and the Advisory Board.

(2) Establish, oversee, administer, and provide ongoing support of a successor HIE Network to the HIE Network established under Article 29A of Chapter 90 of the General Statutes.

(3) Enter into any contracts necessary for the establishment, administration, and operation of the successor HIE Network.

(4) Facilitate the termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(5) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred seventy-seven thousand dollars ($177,000) per month, or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The Authority shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The Authority is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

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

"Article 29B.

"Statewide Health Information Exchange Act.

"**§ 90-414.1. Title.**

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

"**§ 90-414.2. Purpose.**

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

"**§ 90-414.3. Definitions.**

The following definitions apply in this Article:

(1) Business associate. – As defined in 45 C.F.R. § 160.103.

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

(3) Covered entity. – Any entity described in 45 C.F.R. § 160.103 or any other facility or practitioner licensed by the State to provide health care services.

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

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

(6) GDAC. – The North Carolina Government Data Analytics Center.

(7) Health Benefits Authority. – The Authority established under Article 14 of Chapter 143B of the General Statutes to operate the Medicaid and NC Health Choice programs.

(8) HIE Network. – The voluntary, statewide health information exchange network overseen and administered by the Authority.

(9) HIPAA. – The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.

(10) Individual. -- As defined in 45 C.F.R. § 160.103.

(11) North Carolina Health Information Exchange Authority or Authority. – The entity established pursuant to G.S. 90-414.5.

(12) North Carolina Health Information Exchange Advisory Board or Advisory Board. – The Advisory Board established under G.S. 90-414.6.

(13) Opt out. – An individual's affirmative decision to disallow his or her protected health information maintained by or on behalf of one or more specific covered entities from being disclosed to other covered entities through the HIE Network.

(14) Protected health information. – As defined in 45 C.F.R. § 160.103.

(15) Public health purposes. – The public health activities and purposes described in 45 C.F.R. § 164.512(b).

(16) Qualified organization. – An entity designated by the Authority to contract with covered entities on behalf of the Authority to facilitate the participation of such covered entities in the HIE Network.

(17) Research purposes. – Research that meets the standard described in 45 C.F.R. § 164.512(i).

(18) State CIO. – The State Chief Information Officer.

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.

(2) That the Health Benefits Authority needs timely access to claims and clinical information in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.

(3) That making this clinical information available through the HIE Network will improve care coordination within and across health systems, increase care quality, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(b) As a condition of receiving State funds, including Medicaid funds, the following entities shall connect to the HIE Network and submit individual patient demographic and clinical data on services paid for with State funds, including Medicaid funds, based on the findings set forth in subsection (a) of this section and notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2:

(1) Each hospital, as defined in G.S. 131E-76(3), that has an electronic health record system.

(2) Each Medicaid provider.

(3) Each provider that receives State funds for the provision of health services.

(c) The Authority shall give the Health Benefits Authority real-time access to data and information disclosed through the HIE Network. At the request of the Director of the Fiscal Research, Bill Drafting, Research, or Program Evaluation Divisions of the General Assembly for data and information disclosed through the HIE Network or for a consolidation or analysis of the data and information disclosed through the HIE Network, the Authority shall provide the professional staff of these Divisions with data and information responsive to the Director's request. Prior to providing the General Assembly's staff with any data or information disclosed through the HIE Network or with any compilation or analysis of data or information disclosed through the HIE Network, the Authority shall redact any personal identifying information in a manner consistent with the standards specified for de-identification of health information under the HIPAA Privacy Rule, 45 C.F.R. § 164.15, as amended.

"**§ 90-414.4A. State ownership of data disclosed through HIE Network.**

Any data disclosed through the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article shall be and will remain the sole property of the State. Any data or product derived from the data disclosed to the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Authority shall not allow proprietary information it receives pursuant to G.S. 90-414.4 or any other provision of this Article to be used by any person or entity for commercial purposes.

"**§ 90-414.5. North Carolina Health Information Exchange Authority.**

(a) Creation. – There is hereby established the North Carolina Health Information Exchange Authority to oversee and administer the HIE Network in accordance with this Article. The Authority shall be located within the Department of Information Technology and shall be under the supervision, direction, and control of the State CIO. The State CIO shall employ an Authority Director and may delegate to the Authority Director all powers and duties associated with the daily operation of the Authority, its staff, and the performance of the powers and duties set forth in subsection (b) of this section. In making this delegation, however, the State CIO maintains the responsibility for the performance of these powers and duties.

(b) Powers and Duties. – The Authority has the following powers and duties:

(1) Oversee and administer the HIE Network in a manner that ensures all of the following:

a. Compliance with this Article.

b. Compliance with HIPAA and any rules adopted under HIPAA, including the Privacy Rule and Security Rule.

c. Compliance with the terms of any business associate contract the Authority or qualified organization enters into with a covered entity participating in the HIE Network.

d. Notice to the patient by the provider on the initial visit about the HIE Network, including information and education about the right of individuals on a continuing basis to opt out or rescind a decision to opt out.

e. Opportunity for all individuals to exercise on a continuing basis the right to opt out or rescind a decision to opt out.

f. Nondiscriminatory treatment by covered entities of individuals who exercise the right to opt out.

(2) Employ staff necessary to carry out the provisions of this Article and determine the compensation, duties, and other terms and conditions of employment of hired staff.

(3) Enter into contracts pertaining to the oversight and administration of the HIE Network, including contracts of a consulting or advisory nature. G.S. 143-64.20 does not apply to this subdivision.

(4) Establish fees approved by the General Assembly for participation in the HIE Network.

(5) Following consultation with the Advisory Board, develop and enter into written participation agreements with covered entities that utilize the HIE Network. The participation agreements shall specify the terms and conditions governing participation in the HIE Network. The agreement shall also require compliance with policies developed by the Authority pursuant to this Article or pursuant to applicable laws of the state of residence for entities located outside of North Carolina. In lieu of entering into a participation agreement directly with covered entities, the Authority may enter into participation agreements with qualified organizations, which in turn enter into participation agreements with covered entities.

(6) Add, remove, disclose, and access protected health information through the HIE Network in accordance with this Article.

(7) Following consultation with the Advisory Board, enter into a business associate contract with each of the covered entities participating in the HIE Network. In lieu of entering into a business associate contract directly with covered entities, the Authority may enter into business associate contracts

with qualified organizations, which in turn may enter into business associate contracts with covered entities.

(8) Following consultation with the Advisory Board, grant user rights to the HIE Network to business associates of covered entities participating in the HIE Network (i) at the request of the covered entities and (ii) at the discretion of the Authority upon consideration of the business associates' legitimate need for utilizing the HIE Network and privacy and security concerns.

(9) Facilitate and promote use of the HIE Network by covered entities.

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

(11) Collect clinical health data from all Medicaid providers and other providers that receive State funds for the provision of health services in order to ensure the efficient delivery of Medicaid and other health services and to improve patient outcomes and measure performance.

(12) Collaborate with the State CIO to ensure that resources available through the GDAC are properly leveraged, assigned, or deployed to support the work of the Authority. The duty to collaborate under this subdivision includes collaboration on data hosting and development, implementation, operation, and maintenance of the HIE Network.

(13) Initiate or direct expansion of existing public-private partnerships within the GDAC as necessary to meet the requirements, duties, and obligations of the Authority. Notwithstanding any other provision of law and subject to the availability of funds, the State CIO, at the request of the Authority, shall assist and facilitate expansion of existing contracts related to the HIE Network, provided that such request is made in writing by the Authority to the State CIO with reference to specific requirements set forth in this Article.

(14) In consultation with the Advisory Board, develop a strategic plan for achieving statewide participation in the HIE Network by all hospitals and health care providers licensed in this State.

(15) In consultation with the Advisory Board, define the following with respect to operation of the HIE Network:

a. Business policy.

b. Protocols for data integrity, data sharing, data security, HIPAA compliance, and business intelligence as defined in G.S. 143B-426.38A. To the extent permitted by HIPAA, protocols for data sharing shall allow for the disclosure of data for academic research.

c. Qualitative and quantitative performance measures.

d. An operational budget and assumptions.

(16) Annually report to the Joint Legislative Oversight Committees on the Health Benefits Authority and Information Technology on the following:

a. The operation of the HIE Network.

b. Any efforts or progress in expanding participation in the HIE Network.

c. Health care trends based on information disclosed through the HIE Network.

"**§ 90-414.6. North Carolina Health Information Exchange Advisory Board.**

(a) Creation and Membership. – There is hereby established the North Carolina Health Information Exchange Advisory Board within the Department of Information Technology. The Advisory Board shall consist of the following nine members:

(1) The following three members appointed by the President Pro Tempore of the Senate:
a. A licensed physician in good standing and actively practicing in this State.
b. A patient representative.
c. An individual with technical expertise in health data analytics.
(2) The following three members appointed by the Speaker of the House of Representatives:
a. A representative of a critical access hospital.
b. A representative of a federally qualified health center.
c. An individual with technical expertise in health information technology.
(3) The following three ex officio, nonvoting members:
a. The State Chief Information Officer or a designee.
b. The Program Manager of GDAC or a designee.
c. The Chief Executive Officer of the Health Benefits Authority or a designee.

(b) Chairperson. – A chairperson shall be elected from among the members. The chairperson shall organize and direct the work of the Advisory Board.

(c) Administrative Support. – The Department of Information Technology shall provide necessary clerical and administrative support to the Advisory Board.

(d) Meetings. – The Advisory Board shall meet at least quarterly and at the call of the chairperson. A majority of the Advisory Board constitutes a quorum for the transaction of business.

(e) Terms. – In order to stagger terms, in making initial appointments, the President Pro Tempore of the Senate shall designate two of the members appointed under subdivision (1) of subsection (a) of this section to serve for a one-year period from the date of appointment, and the Speaker of the House of Representatives shall designate two members appointed under subdivision (2) of subsection (a) of this section to serve for a one-year period from the date of appointment. The remaining voting members shall serve two-year periods. Future appointees who are voting members shall serve terms of two years, with staggered terms based on this subsection. Voting members may serve up to two consecutive terms, not including the abbreviated two-year terms that establish staggered terms or terms of less than two years that result from the filling of a vacancy. Ex officio, nonvoting members are not subject to these term limits. A vacancy other than by expiration of a term shall be filled by the appointing authority.

(f) Expenses. – Members of the Advisory Board who are State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-6. Members of the Advisory Board who are full-time salaried public officers or employees other than State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-5(b). All other members of the Advisory Board may receive compensation and reimbursement for expenses in accordance with G.S. 138-5.

(g) Duties. – The Advisory Board shall provide consultation to the Authority with respect to the advancement, administration, and operation of the HIE Network and on matters pertaining to health information exchange, generally. In carrying out its responsibilities, the Advisory Board may form committees of the Advisory Board to examine particular issues related to the advancement, administration, or operation of the HIE Network.

"**§ 90-414.7. Participation by covered entities.**

(a) Each covered entity that elects to participate in the HIE Network shall enter into a business associate contract and a written participation agreement with the Authority or

qualified organization prior to disclosing or accessing any protected health information through the HIE Network.

(b) Each covered entity that elects to participate in the HIE Network may authorize its business associates to disclose or access protected health information on behalf of the covered entity through the HIE Network in accordance with this Article and at the discretion of the Authority, as provided in G.S. 90-414.5(b)(8).

(c) Notwithstanding any State law or regulation to the contrary, each covered entity that elects to participate in the HIE Network may disclose an individual's protected health information through the HIE Network (i) to other covered entities for any purpose permitted by HIPAA, unless the individual has exercised the right to opt out, and (ii) in order to facilitate the provision of emergency medical treatment to the individual, subject to the requirements set forth in G.S. 90-414.8(e).

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

"**§ 90-414.8. Continuing right to opt out; effect of opt out; exception for emergency medical treatment.**

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

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

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

(d) Except as otherwise permitted in subsection (e) of this section and G.S. 90-414.9(a)(3), the protected health information of an individual who has exercised the right to opt out may not be disclosed to covered entities through the HIE Network for any purpose.

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

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

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

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

"**§ 90-414.9. Construction and applicability.**

(a) Nothing in this Article shall be construed to do any of the following:
(1) Impair any rights conferred upon an individual under HIPAA, including all of the following rights related to an individual's protected health information:
a. The right to receive a notice of privacy practices.
b. The right to request restriction of use and disclosure.
c. The right of access to inspect and obtain copies.
d. The right to request amendment.
e. The right to request confidential forms of communication.
f. The right to receive an accounting of disclosures.
(2) Authorize the disclosure of protected health information through the HIE Network to the extent that the disclosure is restricted by federal laws or regulations, including the federal drug and alcohol confidentiality regulations set forth in 42 C.F.R. Part 2.
(3) Restrict the disclosure of protected health information through the HIE Network for public health purposes or research purposes, so long as disclosure is permitted by both HIPAA and State law.
(4) Prohibit the Authority or any covered entity participating in the HIE Network from maintaining in the Authority's or qualified organization's computer system a copy of the protected health information of an individual who has exercised the right to opt out, as long as the Authority or the qualified organization does not access, use, or disclose the individual's protected health information for any purpose other than for necessary system maintenance or as required by federal or State law.

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

"**§ 90-414.10. Penalties and remedies.**

A covered entity that discloses protected health information in violation of this Article is subject to the following:
(1) Any civil penalty or criminal penalty, or both, that may be imposed on the covered entity pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, P.L. 111-5, Div. A, Title XIII, section 13001, as amended, and any regulations adopted under the HITECH Act.
(2) Any civil remedy under the HITECH Act or any regulations adopted under the HITECH Act that is available to the Attorney General or to an individual who has been harmed by a violation of this Article, including damages, penalties, attorneys' fees, and costs.
(3) Disciplinary action by the respective licensing board or regulatory agency with jurisdiction over the covered entity.
(4) Any penalty authorized under Article 2A of Chapter 75 of the General Statutes if the violation of this Article is also a violation of Article 2A of Chapter 75 of the General Statutes.
(5) Any other civil or administrative remedy available to a plaintiff by State or federal law or equity."

SECTION 2.(e) G.S. 126-5 is amended by adding a new subdivision to read:

"**§ 126-5. Employees subject to Chapter; exemptions.**

...

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

...

(31) Employees of the North Carolina Health Information Exchange Authority."

SECTION 2.(f) Article 29A of Chapter 90 of the General Statutes is repealed.

SECTION 2.(g) Subsections (d) and (e) of this section become effective October 1, 2015. Subsection (f) of this section becomes effective on the date the State Chief Information Officer notifies the Revisor of Statutes that all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE, as defined in G.S. 90-413.3, and (ii) between the NC HIE and any third parties have been terminated or assigned to the North Carolina Health Information Exchange Authority established under Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The remainder of this section becomes effective July 1, 2015.

INCREASE RATES TO PRIMARY CARE PHYSICIANS AND DISCONTINUE PRIMARY CARE CASE MANAGEMENT

SECTION 3.(a) Effective May 1, 2016, the current Medicaid and Health Choice primary care case management (PCCM) program is discontinued. The Department of Health and Human Services shall not renew or extend the contract for PCCM services with North Carolina Community Care Networks, Inc. (NCCCN), beyond April 30, 2016.

SECTION 3.(b) The Department of Health and Human Services shall take all actions necessary to discontinue the current Medicaid and Health Choice PCCM program as implemented by NCCCN. As soon as reasonably possible, but no later than February 1, 2016, the Department shall submit to the Centers for Medicare and Medicaid Services (CMS) a Medicaid State plan amendment eliminating the PCCM program. If CMS has not approved the State plan amendment by May 1, 2016, the Department of Health and Human Services nevertheless shall discontinue all payments related to the PCCM program beginning May 1, 2016, unless and until CMS denies the State plan amendment.

SECTION 3.(c) This section shall not be construed to prohibit the Department of Health and Human Services from developing or utilizing contracts for managed care other than PCCM after May 1, 2016.

SECTION 3.(d) Effective May 1, 2016, G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

...

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

~~The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers the per member, per month fees as allowed under Medicaid.~~"

SECTION 3.(e) Effective May 1, 2016, the rates paid to primary care physicians shall be one hundred percent (100%) of Medicare rates. For purposes of this section, the term primary care physicians refers to those physicians for whom the Affordable Care Act required payment at one hundred percent (100%) of the Medicare rate until January 1, 2015, and all OB/GYN physicians.

SECTION 3.(f) The General Assembly finds that the discontinuation of the PCCM program and the NCCCN contract as required by this section will save a recurring sum of ten million eight hundred twenty-five thousand dollars ($10,825,000) in fiscal year 2015-2016 and

sixty-four million nine hundred fifty thousand dollars ($64,950,000) in fiscal year 2016-2017. As a result of these savings, appropriations are made as follows: the recurring sum of eight million four hundred thirty-four thousand three hundred thirteen dollars ($8,434,313) in fiscal year 2015-2016 and fifty million six hundred five thousand eight hundred eighty dollars ($50,605,880) in fiscal year 2016-2017 is appropriated to the Department of Health and Human Services, Division of Medical Assistance, to pay for the increased Medicaid rates required by subsection (e) of this section, and the recurring sum of two million one hundred fifty-eight thousand three hundred thirty-three dollars ($2,158,333) in fiscal year 2015-2016 and twelve million nine hundred fifty thousand dollars ($12,950,000) in fiscal year 2016-2017 is appropriated to the Department of Health and Human Services, Division of Medical Assistance, to directly fund local health departments' continued services related to the Care Coordination for Children (CC4C) program, which was previously funded through the contract with NCCCN.

SECTION 3.(g) This section is effective when this act becomes law.

SECTION 4. Except as otherwise provided, this act is effective when it becomes law.

HOUSE BILL 372:
2015 Medicaid Modernization

2015-2016 General Assembly

Committee:	Senate Sequential Referral To Appropriations/Base Budget Added	**Date:**	August 5, 2015
Introduced by:	Reps. Dollar, Lambeth, B. Brown, Jones	**Prepared by:**	Jennifer Hillman* Staff Attorney
Analysis of:	PCS to Third Edition H372-CSTR-4		

SUMMARY: ***The PCS for HB 372 would change the operational structure and administrative oversight for the Medicaid and NC Health Choice programs, enact the Statewide Health Information Exchange (HIE) Act, and provide for the discontinuation of the Medicaid primary care case management (PCCM) program. The new Medicaid and Health Choice programs would feature: full-risk capitated payments to commercial insurers and provider-led entities (PLEs); management by a newly created Department of Medicaid; and oversight by a newly created Joint Legislative Oversight Committee. The HIE Act would require participation from specified providers and create both an HIE Authority and an HIE Advisory Board. The current Medicaid PCCM program would be discontinued to provide funding for increased Medicaid rates to primary care physicians.***

BILL ANALYSIS: Section 1 pertains to the **Medicaid Transformation and Reorganization**, **Section 2** pertains to the **Statewide Health Information Exchange**, and **Section 3** pertains to **Medicaid Primary Care Case Management**. The various Sections of the PCS have been outlined below.

Medicaid Transformation - Section 1 of the PCS addresses the plan for Medicaid transformation. The plan features full-risk capitated contracts with commercial insurers and provider-led entities, which would be responsible for the provision of all services to all Medicaid and Health Choice beneficiaries except dual eligibles. A newly-created independent agency, the Department of Medicaid (DOM), would oversee the transition and would become the single state agency responsible for the programs on January 1, 2016. The Department of Health and Human Services (DHHS) would continue to operate the current Medicaid and Health Choice programs until the transition to capitated payments is complete.

Section 1(a) outlines the intent and goals of the transformation. **Section 1(b)** outlines the structure of the delivery system which requires contracts with Medicaid managed care organizations (MCOs), which is defined to include commercial insurers and provider-led entities (PLEs). **Section 1(c)** provides a timeline for the transformation. **Section 1(d)** outlines the following components: Requests for Proposals (RFP); bid submission; terms and conditions of contracts. **Section 1(e)** requires a monthly progress report, from February 1, 2016 through January 1, 2019, to a newly created Joint Legislative Oversight Committee on Medicaid (LOC on Medicaid). **Section 1(f)** requires working with the Centers for Medicare and Medicaid Services (CMS) to preserve existing funding streams, such as assessments, with a goal of ensuring that funding streams are more closely aligned to improving health outcomes and achieving Medicaid goals. **Section 1(g)** outlines the role of the Department of Health and Human Services (DHHS) in the transformation including: agreements for supervision of the program's administration during the transition; organization and identification of a stabilization team; identification and designation of "essential positions" necessary for day-to-day operation and the provision of certain benefits for those employees; and a prohibition on DHHS from entering into contracts without approval

by the new DOM. **Sections 1(h)** pertains to the creation of a new cabinet-level department to administer and operate the Medicaid and NC Health Choice programs and provides for the transfer of all functions, powers, duties, obligations and services vested in the DHHS Division of Medical Assistance (DMA) to the new DOM**. Section 1(i)** amends Chapter 143B of the General Statutes to create a new Article 14 to create the new Department of Medicaid (DOM). The new Article creates the DOM, outlines the powers and duties of the Secretary of Medicaid, provides for variations from certain State laws, specifies the cooling off period for certain employees, and establishes a Medicaid Reserve Account. **Section 1(j)** provides that effective January 1, 2016, all rules and policies exempted from rule making related to Medicaid and NC Health Choice programs will transfer to the DOM and that a May 1, 2016 report to the LOC on Medicaid must include recommendations for additional rule-making requirements under Chapter 150B of the General Statutes. **Sections 1(k) and (k1)** pertain to legal actions involving Medicaid and NC Health Choice programs and provide that the Commissioner of Insurance shall establish solvency requirements for the MCOs and PLEs referenced in this bill. **Section 1(l)** establishes a Joint Legislative Oversight Committee on Medicaid consisting of 14 members charged with examining the budgeting, financing, administrative, and operational issues related to Medicaid and NC Health Choice Programs. **Section 1(m)** makes a conforming change for the newly created LOC on Medicaid to amend G.S. 120-208.1(a)(2)b removing oversight of "Medical Assistance" from the purview of the Joint Legislative Oversight Committee on Health and Human Services. **Section 1(n)** directs the Revisor of Statutes to recodify existing law to reflect the structure reflected by the changes in this bill. **Section 1(o)** amends G.S. 108A-1 to make changes conforming to this bill. **Section 1(p)** amends G.S. 108A-54.1A to provide that the DOM is authorized and required to take any and all necessary action to amend the Medicaid State Plan and waivers in order to keep the program within the certified budget. **Section 1(q)** repeals G.S. 108A-54.2(d) which currently imposes limitations on DHHS's ability to change medical policy unless directed by the General Assembly. **Section 1(r)** creates G.S. 108E-2-1 to provide that the General Assembly sets eligibility categories and income thresholds and G.S. 108E-2-2 to provide that counties determine eligibility in accordance with Chapter 108A. **Section 1(s)** amends G.S. 126-5 to exempt employees of the DOM from all but Article 6 (Equal Employment and Compensation Opportunity, Assisting in Obtaining State Employment) and Article 7 (Privacy of State Employee Personnel Records) of the State Human Resources Act. **Sections 1(t) and (u)** amend G.S. 143B-153 and G.S. 150B-1 to make conforming changes utilizing the DOM name. **Section 1(v)** appropriates $5,000,000 in recurring funds for the 2015-16 and 2016-17 fiscal years to accomplish the transformation. The funds provide a State match for $5,000,000 in federal funds. **Section 1(w)** provides Section 1(n) through Section 1(u) become effective January 1, 2016 and the remainder of Section 1 is effective when it becomes law.

The following chart compares key features of the PCS to HB 372, v3:

	PCS to Third Edition (Senate)	Third Edition (House)
Who conducts reform?	New Department of Medicaid (DOM) ***an independent agency, headed by a Secretary appointed by the Governor and confirmed by the General Assembly)*	Existing Department of Health and Human Services ***advised by newly created Quality Assurance Advisory Committee*
Basic goal	"…transform the State's current Medicaid program to a system that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need."	Same
Payment structure	Full-risk capitated health plans	Same

Who can contract for payment?	Provider-led entities (PLEs) and commercial insurers	Provider-led entities (PLEs) only
	PCS to Third Edition (Senate)	**Third Edition (House)**
Geographical coverage of contracts	3 statewide contracts and up to 12 regional contracts in 5-8 regions to be set by the new DOM	Individual contracts must cover at least 30,000 lives and may cover less than the entire State; contracts in aggregate must cover entire State
Covered populations	All Medicaid beneficiaries except dual-eligible categories	90% of all Medicaid beneficiaries statewide; excludes dual eligibles
Covered services	All services, except LME/MCO services will be a pass-through contract during the initial contract period; no primary care case management	All services except LME/MCO services, dental, and drugs/pharmacy; builds on existing enhanced primary care medical home model
Timeline for implementation	Full implementation 12 months after approval of the plan by the federal government, with submission of documents to the federal government required by May 1, 2016	Full implementation of capitated payments within 5 years of enactment (approx. 2020); Performance and quality goals must be met within 6 years of enactment (approx. 2021)
Legislative Oversight	New Legislative Oversight Committee on the Medicaid	same

Statewide Health Information Exchange - **Section 2** of the PCS addresses the plan for the Statewide Health Information Exchange (HIE) Network. **Section 2(a)** provides the intent of the General Assembly with regard to the HIE. **Section 2(b)** appropriates $8,000,000 in recurring funds for the 2015-16 and 2016-17 fiscal years to continue efforts toward the implementation of a statewide health information exchange network. The Secretary of DHHS and the State Chief Information Officer (CIO) must enter into a memorandum of understanding (MOU) so that the State CIO will have sole authority to direct the expenditure of funds appropriated to DHHS for the statewide health information exchange until such time as (i) the NC HIE Authority is established and the State CIO has appointed an Authority Director, and the NC HIE Advisory Board is established. **Section 2(c)** directs that once the HIE Authority Director has been hired and Advisory Board members have been appointed, the HIE Authority will assume responsibility for the funds appropriated to DHHS and can expend the funds for specified tasks, including facilitating the termination of or assignment to the Authority of all contracts pertaining the State's existing HIE Network by December 31, 2015. **Section 2(d)** amends Chapter 90 of the General Statutes to add a new Article 29B. Statewide Health Information Exchange Act. The new Act mirrors the NC Health Information Exchange Act, but expands mandatory participation in the successor HIE Network beyond just hospitals with electronic health record systems to Medicaid providers and all providers that receive State funds for the provision of health services. Receipt of State funds, including Medicaid funds, is conditioned upon these entities fulfilling the mandatory participation requirements. The Statewide Health Information Exchange Act includes the following components: purpose; definitions; required participation in the HIE Network for some providers; State ownership of data disclosed through HIE Network; creation of the NC HIE Authority; creation of the NC HIE Advisory Board; participation by covered entities; right to opt out, effect of opt out, exception for emergency medical treatment; construction and applicability; penalties and remedies. **Section 2(e)** amends G.S. 126-5 to exempt employees of the North Carolina Health Information Exchange Authority from all but Article 6 (Equal Employment and Compensation Opportunity, Assisting in Obtaining State

Employment) and Article 7 (Privacy of State Employee Personnel Records) of the NC Human Resources Act. **Section 2(f)** repeals Article 29A of Chapter 90 which is the current North Carolina Health Information Exchange Act. **Section 2(g)** sets out the effective dates for Section 2. It provides that Section 2(d) and Section 2(e) become effective October 1, 2015. Section 2(f) becomes effective on the date the State CIO notifies the Revisor of Statutes that all contracts pertaining to the HIE Network (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties have been terminated or assigned to the NC HIE Authority. The remainder of the section becomes effective July 1, 2015.

Medicaid Primary Care Case Management - **Section 3** of the PCS addresses the current Medicaid and NC Health Choice primary care case management (PCCM) program. **Section 3(a)** directs the discontinuation of the PCCM program effective May 1, 2016 and prohibits renewal of the current contract for PCCM with North Carolina Community Care Networks, Inc, (NCCCN) beyond April 30, 2016. **Section 3(b)** directs DHHS to submit a State Plan amendment to the federal government no later than February 1, 2016 to discontinue the PCCM program and directs DHHS to discontinue payments related to the PCCM program effective May 1, 2016 unless and until the state plan amendment is denied. **Section 3(c)** clarifies that DHHS may develop or utilize contracts for managed care other than PCCM after May 1, 2016. **Section 3(d)** makes a conforming change to G.S. 108A-70.21(b) governing NC Health Choice. **Section 3(e)** increases the Medicaid rate paid to primary care physicians to 100% of Medicare rates effective May 1, 2016. **Section 3(f)** makes findings regarding savings to the Medicaid program related to discontinuing the PCCM program and the NCCCN contract and appropriates funds to be used to increase rates to primary care physicians and to directly fund local health departments' continued services related to the Care Coordination for Children (CC4C) program, previously funded through the contract with NCCCN.

EFFECTIVE DATE: The effective dates have been provided within the summary. Except as otherwise provided, this act is effective would become when it becomes law.

**Theresa Matula, Senate Health Committee Staff, and Joyce Jones, Staff Attorney with the Legislative Drafting Division, substantially contributed to this summary.*

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

August 6, 2015

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Douglas Holbrook	NCSBA
Ken Melton	Brooks
Aedis Watkins	SEANC
David Collins	SEANC
Bill Rowe	NC Justice Ctr
Tom Friedman	DST/STP
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John Delbrondo	Brubaker Assoc.
Cortney Lokamy	Randolph Cloud & Assoc
John McMillan	MFAE
Kay Castillo	NASW-NC
Colleen Kachmarek	KLG

09-21-201

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Senate Committee on Health Care

August 6, 2015

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Annaliese Dolph	DL
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Starnes	OST
Solari	

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Senate Committee on Health Care

August 6, 2015

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Wendy Kelly	Focus - Carolinas
Joe Dancy	Cardinal
Allison Stewart	Cardinal
Chris McClure	BSP
Jonathan Bernbaden	~~BIA~~
Hayden Byars	FSP
Jim Farrell	BIA
Gary Pendo	NCAA
Joe Mannarino	GSK & Assoc
GERRY CONTIN	NMRS
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Becki Gray	JLF
Charles Logan	John Locke Foundation
Carol Meyer	The Carolinas Center for Hospice
Lisa Martin	Cap-Ad

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August 6, 2015

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Alan [illegible]	VCG
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Amanda Honaker	TSS
Amber Harris	NCACC
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[illegible]	RJC1
David Heinen	NC Center for Nonprofits
[illegible]	[illegible]
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[illegible]	[illegible]
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09-21-201

Rob Lamm

RBA

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Senate Committee on Health Care

August 6, 2015

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	CCL
	GSK
CS Hollis	
	NCMS
	NCAFF
	WakeMed
Holly Heath-Shepard	NC Brain Injury Advisory Council
	NC Foot & Ankle
	PSG
	JDA
	Amerigroup
	FSP

09-21-201

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Senate Committee on Health Care

August 6, 2015

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Skye David	KLG
Kelli Kuhlo	Duke Energy
Nelson Freeman	DOT

09-21-201

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Senate Committee on Health Care

August 6, 2015

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Lori Kroll	Novant Health
Daniel VanLiere	Vidant Health
Andy Ellen	NCRMA

Senate Committee on Health Care
Tuesday, May 3, 2016 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 3, 2016, in Room 544 of the Legislative Office Building. Sixteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing the pages—Kenton Shelton of Hope Mills, Lacey Peterson of Apex, Jada Peterson of Rocky Mount, Kayla Welch of Edenton, Mikayla Medley of Rolesville, Joseph Canney of New Bern, Dymand Covington of Raleigh, Elizabeth White of Deep Gap, and Michael Glennon of Willow Spring; and the Sergeants-at-Arms—Frances Patterson and Hal Roach.

Senator Hise announced that Senate Bill 736–Study Suicide Prevention needed a bit more work, and would not be taken up in committee that day.

Senator Hise then recognized Senator Pate to present Senate Bill 734–Statewide Standing Order/Opioid Antagonist. Senator Pate recognized Dr. Randall Williams, State Health Director, Deputy Secretary of Health Services, DHHS, to join him in presenting the bill. Senator Pate and Dr. Williams spoke on the need for the bill. After questions and answers from committee members, Senator Barefoot moved for a favorable report to the bill. The motion passed and the bill was referred to Judiciary I.

The meeting adjourned at 11:22 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
Tuesday	May 3, 2016	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 734	Statewide Standing Order/Opioid Antagonist.	Senator Pate Senator Tucker Senator Robinson
SB 736	Study Suicide Prevention.	Senator Pate Senator Robinson

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

Senate Committee on Health Care
Tuesday, May 3, 2016, 11:00 AM
544 Legislative Office Building

AGENDA

Senator Ralph Hise Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 734	Statewide Standing Order/Opioid Antagonist.	Senator Pate Senator Tucker Senator Robinson
SB 736	Study Suicide Prevention.	Senator Pate Senator Robinson

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, May 03, 2016

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

FAVORABLE

SB **734** Statewide Standing Order/Opioid Antagonist.

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

TOTAL REPORTED: 1

Senator Louis Pate will handle SB 734

SENATE BILL 734:
Statewide Standing Order/Opioid Antagonist.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	May 2, 2016
Introduced by:	Sens. Pate, Tucker, Robinson	**Prepared by:**	Theresa Matula
Analysis of:	First Edition		Committee Staff

SUMMARY: ***Senate Bill 734 amends the law on drug-related overdose treatment to specifically authorize the State Health Director to issue a statewide standing order for an opioid antagonist which would allow the overdose treatment drug to be more readily accessible. Current law allows a practitioner to prescribe an opioid antagonist directly, or by standing order, to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. This bill is a recommendation of the Joint Legislative Oversight Committee on Health and Human Services.***

CURRENT LAW: G.S. 90-106.2 Drug-related overdose treatment; limited immunity, as enacted by S.L. 2013-23, and amended by S.L. 2015-94, is outlined below:

Opioid Antagonist - Subsection (a) provides that "opioid antagonist" means naloxone hydrochloride.
Practitioner authorized to prescribe directly or by standing order - Subsection (b) authorizes a practitioner acting in good faith and exercising reasonable care to prescribe directly, or by standing order, an opioid antagonist to: (i) a person at risk of experiencing an opiate-related overdose, or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.
Dispense - Subsection (b1) allows a pharmacist to dispense an opioid antagonist pursuant to subsection (b).
Administer- Subsection (c) provides that a person who receives an opioid antagonist prescribed pursuant to subsection (b), may administer an opioid antagonist to another person if (i) the person has a good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.
Immunity - Subsection (d) provides that any practitioner who prescribes, pharmacist who dispenses, or person who administers, an opioid antagonist pursuant to this section is immune from any civil or criminal liability for authorized actions.

G.S. 130A-3 requires the State Health Director, appointed by the Secretary of Health and Human Services, to be a physician licensed to practice medicine in this State.

BILL ANALYSIS: Senate Bill 734 amends G.S. 90-106.2(b) to add a new subdivision specifically authorizing the State Health Director to prescribe an opioid antagonist pursuant to current law and by means of a statewide standing order. Subsection (d) of this section is amended to specifically list the State Health Director among those individuals who are statutorily granted immunity from civil or criminal liability for actions authorized by the section.

EFFECTIVE DATE: Senate Bill 734 would become effective when it becomes law.

Karen Cochrane-Brown
Director

S734-SMSH-127 E1 -V-4

Legislative Analysis Division
919-733-2578

BACKGROUND: The Joint Legislative Oversight Committee on Health and Human Services heard a presentation and received handouts on April 12, 2016, regarding the need for a statewide standing order for naloxone. Naloxone hydrochloride is a opioid antagonist that reverses the effects of opioids (heroin and prescription drugs such as methadone, oxycodone, and hydrocodone). According to the Department of Health and Human Services (DHHS), "[b]etween 1999 and 2014, the number of unintentional medication or drug overdose deaths increased by over 330 percent in North Carolina." Under State law, a pharmacy cannot dispense naloxone without a prescription or standing order issued by a practitioner. A standing order signed by the North Carolina State Health Director would authorize any pharmacist practicing in the state of North Carolina to dispense naloxone. Routes of naloxone administration include intranasal and intramuscular (shoulder or thigh) and each person dispensed naloxone would receive education regarding use and the risk factors.

Since the enactment of SL 2013-23 and SL 2015-94, entities across the State have established naloxone dispensing programs. In August 2015, local health departments received information on adopting naloxone standing orders. S.L. 2015-241, Sec 12F.15, provided funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuses Services, DHHS, to purchase opioid antagonists for distribution by the NC Harm Reduction Coalition (NCHRC) and for distribution to NC law enforcement agencies. The NCHRC website provides access to Overdose Rescue 101, an information sheet on naloxone, and lists contacts for and locations where overdose rescue kits may be obtained. The DHHS reports that since August 2013, naloxone has been used to reverse more than 1,500 overdoses in North Carolina.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1*

SENATE BILL 734*

Short Title:	Statewide Standing Order/Opioid Antagonist.	(Public)
Sponsors:	Senators Pate, Tucker, Robinson (Primary Sponsors); and J. Davis.	
Referred to:	Health Care	

April 26, 2016

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE STATE HEALTH DIRECTOR TO PRESCRIBE OPIOID ANTAGONIST BY MEANS OF A STATEWIDE STANDING ORDER, WITH IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR SUCH ACTION, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-106.2 reads as rewritten:

"**§ 90-106.2. Treatment of overdose with opioid antagonist; immunity.**

(a) As used in this section, "opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose.

(b) The following individuals may prescribe an opioid antagonist in the manner prescribed by this subsection:

(1) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to (i) a person at risk of experiencing an opiate-related overdose or (ii) a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose. As an indicator of good faith, the practitioner, prior to prescribing an opioid under this subsection, may require receipt of a written communication that provides a factual basis for a reasonable conclusion as to either of the following:

~~(1)~~a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

~~(2)~~b. The person other than the person who is at risk of experiencing an opiate-related overdose, and who is seeking the opioid antagonist, is in relation to the person at risk of experiencing an opiate-related overdose:

~~a.~~1. A family member, friend, or other person.

~~b.~~2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(b1) A pharmacist may dispense an opioid antagonist to a person described in subsection (b) of this section pursuant to a prescription issued in accordance with subsection (b) of this section. For purposes of this section, the term "pharmacist" is as defined in G.S. 90-85.3.

(c) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section may administer an opioid antagonist to another person if (i) the person has a

good faith belief that the other person is experiencing a drug-related overdose and (ii) the person exercises reasonable care in administering the drug to the other person. Evidence of the use of reasonable care in administering the drug shall include the receipt of basic instruction and information on how to administer the opioid antagonist.

(d) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) ~~Any~~ The State Health Director and any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(1a) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (b1) of this section.

(2) Any person who administers an opioid antagonist pursuant to subsection (c) of this section."

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

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

May 3, 2016

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Margaret Dyke	DMVA
Kara Weishaar	SA
Logi Kroll	Novant Health
	NCRM
	TLA
Emily Callen	PPSAT
Tessie Castillo	NLHRC
Marty Babock	Prime Therapeutics
Alex Miller	AIAGA
Skye Dowd	AIAGA
Kelly Vogel	KV Strategies
	BI
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09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

May 3, 2016

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
David Kolbacker	NC Board of Nursing
Tom Vitaglione	NC CHILD
[illegible]	[illegible]
Thom Goolsby	Capitol Government Relations
Jeff Moore	North State Journal
[illegible]	[illegible]
Heather Englehart	Benchmarks
Laura Cranford	NCBID
John DelGiorno	Brubaker+Assoc
Kathy Higgsbury	BP
Phoebe Landon	mvc llc
Rivian Mcnaild	
Tim Bradley	NC SFA
Dick Carlton	Law Off of RH Carlton PLLC
Donna Clark	UNC SG
Dave Hamm	Smith Anderson
Margie Fortenberry	NCAE

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
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Kella Hatcher	CFTF
Joe Maynard	GPM & Assoc
Angel Sams	WCSR
[illegible]	NCMS
Cody Hand	NCHA
Hugh Johnson	NCACC
Dodie Renfer	CCR
Scott Lassiter	SSGNC
Sarah McQuillan	SSGNC
Elizabeth Meredith	NCMB
[illegible]	AHIP
Matt Grabowski	State Health Plan
Daniel Balm	Troutman Sanders
Jay Campbell	NCBOP
Mike Adams	AeD

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

May 3, 2016

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Tim Chapple	RCNC
Peters	CSS
Joyce Peters	CSS
Ashley Parker	Parker Law
Ann Rodriguez	NC Council of Comm Programs
Kay Castillo	NASW-NC
[illegible]	TCF
Morgan Lunn	DRNC
Jennifer Maham	HSNC
Andy Chase	KMA
Amanda Donovan	TSS
Lori Ann Harris	LHHA
Erin Wynia	NCLM
Ashley Knotts	NCLM

09-21-201

Senate Committee on Health Care
Tuesday, May 17, 2016 at 11:00 am
544 Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 11:05 am on May 17, 2016, in room 544 of the Legislative Office Building. Nineteen members were present.

Senator Tommy Tucker, Chair, presided.

Senator Tucker opened the meeting by welcoming everyone and recognizing the Senate Sergeant-at-Arms – Frances Patterson, Hal Roach and Matt Urben. Senator Hise also recognized the Senate Pages – Drew Fisher of Iredell County (sponsored by Senator Curtis), Noah de Comarmond of Wake County (sponsored by Senator Chaudhuri), Anna Blount of Sampson County (sponsored by Senator Jackson), Jennifer Qian of Orange County (sponsored by Senator Woodard), Kate Taylor of Wilson County (sponsored by Senator Newton), Sanaa Lucas of Forsyth County (sponsored by Senator Lowe) and Hunter Smith of Davie County (sponsored by Senator Brock).

The Committee heard Senate Bill 825. Theresa Matula with staff reviewed the bill followed by questions and comments from Senators McKissick, Rabin, Hartsell and Tucker. Senator McKissick had questions concerning the reporting requirements and the cost/impact on hospitals of which Cody Hand with the NC Hospital Association responded. Senator Rabin had a question about the cost effectiveness of SB 825. Senator Hartsell had a question on hospitals reporting and how do hospitals handle their various entities and reporting. Senator Tucker had a question concerning how they would use the information and if there is a question on the hospital misuse of funds. He asked if we should allocate funds to cover the costs of the hospitals reporting the information.

Senator Hise presented an amendment with Senator Wade motioning for the amendment to move forward. The amendment passed by voice vote.

Senator Wells presented an amendment with Senator Wade motioning for the amendment to move forward. The amendment passed by voice vote.

Senator Wells presented an amendment with Senator Hise motioning for the amendment to move forward. The amendment passed by voice vote.

Senator Wade motioned for the bill to move forward. The motion passed by voice vote with a re-referral to Appropriations/Base Budget.

The Committee heard Senate Bill 830. Senator McInnis presented the bill for discussion purposes only. Senators Wade, Jim Davis, Rabin, Lowe, McKissick, Van Duyn, Tarte, Robinson, Don Davis and Tucker followed with questions and comments.

The Committee heard Senate Bill 838 with Senator Rabin motioning to hear the bill. Senator Hise presented the bill. Senator Wade moved to approve the bill. The motion passed by voice vote.

The Committee heard Senate Bill 841 with Senator Hise presenting the bill. Senator Rabin moved for approval with a re-referral to Appropriations/Base Budget. The motion passed by voice vote.

The meeting adjourned at 12:05 pm.

Senator Tommy Tucker
Presiding

Joey Stansbury
Committee Clerk

Senate Committee on Health Care
Tuesday, May 17, 2016, 11:00 AM
544 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 825	Expand Hospital Disclosure Requirements.	Senator Wells Senator Rucho
SB 830	Add Kratom to Controlled Substance List. For Discussion Only	Senator McInnis
SB 838	Medicaid Transformation Reporting.	Senator Hise
SB 841	Medicaid Eligibility Timeliness/Funds.	Senator HiseSenator Krawiec Senator Foushee

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, May 17, 2016

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

FAVORABLE

SB **841** Medicaid Eligibility Timeliness/Funds.

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

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

SB **825** Expand Hospital Disclosure Requirements.

Draft Number:	S825-PCS15364-BC-1
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

SB **838** Medicaid Transformation Reporting.

Draft Number:	S838-PCS15365-TR-8
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 3

Senator Ralph Hise will handle SB 841
Senator Andy Wells will handle SB 825
Senator Ralph Hise will handle SB 838

SENATE BILL 825:
Expand Hospital Disclosure Requirements.

2016-2017 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget	**Date:**	May 13, 2016
Introduced by:	Sens. Wells, Rucho	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 825 amends the statute governing disclosure of charity care to expand hospital disclosure requirements relating to financial assistance, patient revenue, income, and spending for capital assets and improvements by requiring hospitals and ambulatory surgical facilities to provide this information to the public, post it at their places of business, and submit it to the Department of Health and Human Services (DHHS). DHHS is required to post the information provided by hospitals and ambulatory surgical facilities on its own Web site in a manner that is searchable by facility name. The bill also appropriates $150,000 from the General Fund to DHHS for information technology costs associated with the Department's new responsibilities under the bill.***

CURRENT LAW: G.S. 131E-214.14 requires hospitals and ambulatory surgical facilities to provide public access to their financial assistance policies and financial assistance costs reported on Schedule H, federal form 990. This information must be posted in a prominent place in the hospital or ambulatory surgical facility's place of business and reported annually to DHHS. DHHS is required to post the information on its Web site in a manner that is searchable and not merely links to other websites.

BILL ANALYSIS: **Section 1** of SB 825 amends G.S. 131E-124.14 pertaining to the disclosure by hospitals and ambulatory surgical facilities of charity care/financial assistance, patient revenues, income, and capital assets and improvements as provided below.

Subsections (a)-(a3) of G.S. 131E-214.14 amend the law to require each hospital and ambulatory surgical facility to disclose the following:

- Financial assistance policy, or comparable policy
- Financial assistance costs
- Total net patient revenue
- Net operating income and total net income

On each element outlined above, the hospital or ambulatory surgical facility is required to:

1. Provide the public with access to the information.
2. Submit the information annually to DHHS in the time, manner, and format required by DHHS.
3. Display the information in a conspicuous place in the organization's place of business.

DHHS must post the information it receives in a single location on its own Web site in a manner that is searchable by facility.

Subsection (a4) requires each hospital and ambulatory surgical facility to disclose spending for capital assets and improvements. This information must be provided to the public. Capital assets and

improvements information must be provided to DHHS annually and broken down by: (i) additions to land, (ii) land improvements, (iii) buildings, (iv) movable equipment, and (v) fixed equipment. For each category the hospital or ambulatory surgical facility must indicate the type and amount of all funding or funding mechanisms used to pay for these capital assets and improvements, such as borrowing, capital leasing, case reserves, funded depreciation, donations, or current operating surplus.

Subsection (a5) requires DHHS to calculate and post on its Web site the quotient obtained by dividing the facility's total amount of financial assistance costs by the sum of the facility's total net patient revenue as reported in the facility's financial statements.

Subsection (b) provides definitions for the following terms as they relate to G.S. 131E-214.14: covered officer, financial assistance costs, financial assistance policy, hospital, net operating income, total net income, total net patient revenue, and total spending for capital assets and improvements. "Financial assistance costs" is defined for hospitals or ambulatory surgical facilities that are required to file Schedule H, federal form 990 and for those that are not required to file the form.

Section 2 appropriates $150,000 from the General Fund to the Division of Health Services Regulation in DHHS to be used for information technology costs associated with the Department's responsibilities under this bill.

EFFECTIVE DATE: Section 2, containing the appropriation, becomes effective July 1, 2016. The remainder of the bill becomes effective October 1, 2016.

BACKGROUND: Section 9007 of the Affordable Care Act required hospitals to annually perform a community health needs assessment and report the results of this assessment to the IRS on Schedule H of federal form 990. As originally enacted, 131E-214.14 required hospitals and ambulatory surgical facilities to publicly disclose these assessments and submit them to DHHS. In 2015, 131E-214.14 was amended to require DHHS to post the information it received on its Web site.

SENATE BILL 825

Short Title:	Expand Hospital Disclosure Requirements.	(Public)
Sponsors:	Senators Wells and Rucho (Primary Sponsors).	
Referred to:	Health Care	

May 11, 2016

A BILL TO BE ENTITLED

AN ACT EXPANDING HOSPITAL DISCLOSURE REQUIREMENTS PERTAINING TO CHARITY CARE, PATIENT REVENUES, INCOME, AND CAPITAL ASSETS AND IMPROVEMENTS; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, FOR INFORMATION TECHNOLOGY COSTS ASSOCIATED WITH THE DEPARTMENT'S EXPANDED RESPONSIBILITIES UNDER THESE REQUIREMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-214.14 reads as rewritten:

"**§ 131E-214.14. Disclosure of charity care policy and ~~costs.~~costs, patient revenues, income, and capital assets and improvements.**

(a) ~~Requirements.~~Disclosure of Financial Assistance Policies. – ~~A~~ Each hospital or ambulatory surgical facility ~~required to file Schedule H, federal form 990, under the Code must provide~~ shall disclose its financial assistance policy or a comparable policy in all of the following ways:

(1) Provide the public access to its financial assistance ~~policy and its annual financial assistance costs reported on its Schedule H, federal form 990. The information must be submitted~~policy or a comparable policy.

(2) Submit annually to the Department in the time, manner, and format required by the ~~Department.~~ Department an Internet Web site address for access to its financial assistance policy or a comparable policy. The Department ~~must~~shall post all of the information submitted pursuant to this subsection on its internet Web site in one location and in a manner that is ~~searchable.~~searchable by facility. The posting requirement shall not be satisfied by posting links to internet Web sites. ~~The information must also be displayed~~If a hospital or ambulatory surgical facility does not have a financial assistance policy or comparable policy, or does not provide the Department with the information required by this subdivision, then the Department shall indicate this information on its Internet Web site.

(3) Display its financial assistance policy or a comparable policy in a conspicuous place in the organization's place of business.

(a1) Disclosure of Financial Assistance Costs. – Each hospital or ambulatory surgical facility shall disclose its financial assistance costs in all of the following ways:

(1) Provide the public with access to its financial assistance costs.

(2) Submit annually to the Department in the time, manner, and format required by the Department its financial assistance costs. The Department shall post the

information it receives pursuant to this subsection on its Internet Web site in one location and in the manner required by subsection (a4) of this section. This posting requirement shall not be satisfied by posting links to Internet Web sites.

(3) Display its financial assistance costs in a conspicuous place in the organization's place of business.

(a2) Disclosure of Patient Revenue. – Each hospital or ambulatory surgical facility shall disclose its total net patient revenue in all of the following ways:

(1) Provide the public with access to its total net patient revenue.

(2) Submit annually to the Department in the time, manner, and format required by the Department its total net patient revenue. The Department shall post the information it receives pursuant to this subsection on its Internet Web site in one location and in a manner that is searchable by facility. This posting requirement shall not be satisfied by posting links to Internet Web sites.

(3) Display its total net patient revenue in a conspicuous place in the organization's place of business.

(a3) Disclosure of Income. – Each hospital or ambulatory surgical facility shall disclose its net operating income and total net income in all of the following ways:

(1) Provide the public with access to its net operating income and total net income.

(2) Submit annually to the Department in the time, manner, and format required by the Department its net operating income and total net income. The Department shall post the information it receives pursuant to this subsection on its Internet Web site in one location and in a manner that is searchable by facility. This posting requirement shall not be satisfied by posting links to Internet Web sites.

(3) Display its net operating income and total net income in a conspicuous place in the organization's place of business.

(a4) Disclosure of Spending for Capital Assets and Improvements. – Each hospital or ambulatory surgical facility shall disclose its total spending for capital assets and improvements in all of the following ways:

(1) Provide the public with access to its total spending for capital assets and improvements.

(2) Submit annually to the Department in the time, manner, and format required by the Department its total spending for capital assets and improvements, broken down by the following categories: (i) additions to land, (ii) land improvements, (iii) buildings, (iv) movable equipment, and (v) fixed equipment. For each category, the hospital or ambulatory surgical facility shall indicate the type and amount of all funding or funding mechanisms used to pay for these capital assets and improvements, such as borrowing, capital leasing, cash reserves, funded depreciation, donations, or current operating surplus. The Department shall post the information it receives pursuant to this subsection on its Internet Web site in one location and in a manner that is searchable by facility. This posting requirement shall not be satisfied by posting links to Internet Web sites.

(a5) For each hospital or ambulatory surgical facility subject to the disclosure requirements of this section, the Department shall calculate and post the following information on its Internet Web site in one location and in a manner that is searchable by facility: the quotient obtained by dividing the facility's total amount of financial assistance costs by the sum of the facility's total net patient revenue as reported in the facility's financial statements. This posting requirement shall not be satisfied by posting links to Internet Web sites. If a hospital or ambulatory surgical facility does not provide the Department with the information required by this subdivision, then the Department shall indicate this information on its Internet Web site.

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

(1) Code. – Defined in G.S. 105-228.90.

(1a) Covered officer. – Defined in G.S. 131E-257.2(b2).

(2) Financial assistance costs. – ~~The~~ For a hospital or ambulatory surgical facility required to file Schedule H, federal form 990, under the Code, the information reported on the hospital's Cost Report (CMS 2552-10); Schedule S10 related to charity care, if filed by the hospital or ambulatory surgical facility; and the information reported on Schedule H, federal form 990, related to the organization's financial assistance at cost and the amounts reported on that schedule related to the organization's bad debt expense and the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. For a hospital or ambulatory surgical facility that is not required to file Schedule H, federal form 990, under the Code, the term means the information the hospital or ambulatory surgical facility would report on Schedule H, federal form 990, under the Code, related to the organization's bad debt expense and the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy or a comparable policy, if it were required to file Schedule H, federal form 990, under the Code; and the information reported on the hospital's or ambulatory surgical facility's Cost Report (CMS 2552-10) and on Schedule S10 related to charity care, if the hospital or ambulatory surgical facility files a Cost Report (CMS 2552-10) and Schedule S10.

(3) Financial assistance policy. – A policy that meets the requirements of section 501(r) of the Code.

(4) Hospital. – A facility licensed under Article 2 or Article 5 of this Chapter or Article 2 of Chapter 122C of the General Statutes, but does not include the following:

a. A facility with all of its beds designated for medical type "LTC" (long-term care).

b. A facility with the majority of its beds designated for medical type "PSY-3" (mental retardation).

c. A facility operated by the Division of Adult Correction of the Department of Public Safety.

(5) Net operating income. – The difference between a hospital or ambulatory surgical facility's total net patient revenue and total operating expenses.

(6) Total net income. – The sum of a hospital's or ambulatory surgical facility's net operating income plus its net income from all nonoperating sources.

(7) Total net patient revenue. – The total net patient revenue from the hospital's or ambulatory surgical facility's annual audited financial statement.

(8) Total spending for capital assets and improvements. – The total amount expended by a hospital or ambulatory surgical facility for additions to land, land improvements, buildings, movable equipment, and fixed equipment. In calculating this amount, a hospital shall include the amount of all funding or funding mechanisms used to pay for capital assets and improvements such as borrowing, capital leasing, cash reserves, funded depreciation, donations, and current operating surplus."

SECTION 2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Service Regulation, the sum of one hundred fifty thousand dollars ($150,000) for the 2016-2017 fiscal year, to be used for information technology costs associated with the Department's responsibilities under G.S. 131E-214.14, as amended by Section 1 of this act.

SECTION 3. Section 2 of this act becomes effective July 1, 2016. The remainder of this act becomes effective October 1, 2016.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 825

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

S825-ABC-1 [v.2]

Amends Title [NO]
First Edition

Date _____,2016

Senator Hise

moves to amend the bill on page 2, line 2,
by deleting the reference to "(a4)" and replacing it with "(a5)"
and to amend the bill on page 2, line 48,
by deleting the reference to "subdivision" and replacing it with "subsection".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 825

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

S825-ASH-18 [v.2]

Amends Title [NO]
First Edition

Date _____,2016

Senator Wells

moves to amend the bill on page 3, lines 32 through 33, by inserting the following between the lines:

"(d) A facility that operates on a for profit basis and does not meet the definition contained in G.S. 131E-6(6).".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 825

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

S825-ASH-19 [v.3]

Amends Title [NO]
First Edition

Date _____,2016

Senator Wells

moves to amend the bill on page 1, line 33, by rewriting the line to read:

"facility shall disclose its financial assistance costs restated at current Medicare rates and in all of the following ways:".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Bill passes favorable as amend rolled pcs

SENATE BILL 830:
Add Kratom to Controlled Substance List.

2016-2017 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget	**Date:**	May 16, 2016
Introduced by:	Sen. McInnis	**Prepared by:**	Augustus Willis Committee Counsel
Analysis of:	First Edition		

SUMMARY: Senate Bill 830 would add Mitragynine and 7-Hydroxymitragynine, also known as "kratom" to the list of Schedule I controlled substances in G.S. 90-89.

CURRENT LAW: Kratom is not currently scheduled as a controlled substance by either state or federal law. G.S. 90-89 classifies a Schedule I controlled substance as one with a high potential for abuse, no currently accepted medical use in the United States, or a lack of accepted safety for use in treatment under medical supervision. In addition to substances designated by statute as controlled substances, the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services has the authority to add, delete, or reschedule a substance. Generally, unless otherwise authorized, it is a Class H felony to manufacture, deliver, or possess with the intent to manufacture, sell or deliver a Schedule I controlled substance, and a Class G felony to sell a Schedule I controlled substance.

BILL ANALYSIS: Senate Bill 830 would add kratom to the statutory list of Schedule I controlled substances, subjecting it to the criminal penalties outlined above. The bill would further appropriate $25,000 from the General Fund to the Department of Public Safety for the 2016-17 fiscal year.

EFFECTIVE DATE: The portion adding kratom to the list of Schedule I controlled substances would become effective December 1, 2016 and would apply to all offenses committed on or after that date. The appropriation portion of the bill would become effective July 1, 2016.

BACKGROUND: Kratom is a substance derived from a tree in the coffee family that is native to Southeast Asia. It is sometimes marketed in liquid and pill form for medicinal uses such as the management of pain and/or anxiety. Although it is not an opiate, certain ingredients in kratom bind to opioid receptors in the brain. The federal government does not currently regulate kratom, however, the US Drug Enforcement Administration has listed it as a drug of concern and the US Food and Drug Administration has identified it as a botanical substance that could pose a risk to public health, has warned consumers not to use it, and has authorized seizures of dietary supplements containing kratom. Six states (Alabama, Arkansas, Indiana, Tennessee, Vermont & Wisconsin) have passed laws effectively banning kratom, while two (Illinois & Louisiana) have passed laws prohibiting the sale of kratom to minors. Legislation regulating kratom has been proposed in Florida, Georgia, and Kentucky.

There have been 14 confirmed accidental deaths attributed to kratom poisoning in North Carolina, and 9 others that involved the use of kratom, beginning in 2012. The following data is from the Office of the Chief Medical Examiner:

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

Total cases positive for mitragynine :	23
First case in NC:	June 13, 2012
Latest case in NC:	April 1,2016
Cases per year:	
	2012 - 1
	2013 - 1
	2014 - 7
	2015 - 8
	2016 - 6 (to date)
Average age of decedent:	36 years old
Range of age:	24-49
Manner of death:	
	Accident - 14
	Suicide - 1
	Homicide - 2
	Pending - 6
Means of Death:	
	Gunshot wound - 2
	Asphyxiation - 1
	Pending - 6
	Poisoning with Mitragynine - 14*
	*plus or minus other drugs including heroin, fentanyl, alprazolam, clonazepam and ethanol

SENATE BILL 830

Short Title:	Add Kratom to Controlled Substance List.	(Public)
Sponsors:	Senators McInnis (Primary Sponsor); and Krawiec.	
Referred to:	Health Care	

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO ADD MITRAGYNINE AND 7-HYDROXYMITRAGYNINE, ALSO KNOWN AS KRATOM, TO THE LIST OF CONTROLLED SUBSTANCES AND TO APPROPRIATE FUNDS FOR THE STATE BUREAU OF INVESTIGATION TO ASSIST WITH OPERATING COSTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-89(2) reads as rewritten:

"**§ 90-89. Schedule I controlled substances.**

This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a high potential for abuse, no currently accepted medical use in the United States, or a lack of accepted safety for use in treatment under medical supervision. The following controlled substances are included in this schedule:

...

(2) Any of the following opium derivatives, including their salts, isomers, and salts of isomers, unless specifically excepted, or listed in another schedule, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

a. Acetorphine.
b. Acetyldihydrocodeine.
c. Benzylmorphine.
d. Codeine methylbromide.
e. Codeine-N-Oxide.
f. Cyprenorphine.
g. Desomorphine.
h. Dihydromorphine.
i. Etorphine (except hydrochloride salt).
j. Heroin.
k. Hydromorphinol.
l. Methyldesorphine.
m. Methyldihydromorphine.
n. Morphine methylbromide.
o. Morphine methylsulfonate.
p. Morphine-N-Oxide.
q. Myrophine.

r. Nicocodeine.
s. Nicomorphine.
t. Normorphine.
u. Pholcodine.
v. Thebacon.
w. Drotebanol.
x. Mitragynine.
y. 7-hydroxymitragynine."

SECTION 2. There is appropriated from the General Fund to the Department of Public Safety the sum of twenty-five thousand dollars ($25,000) for the 2016-2017 fiscal year to be allocated to the State Bureau of Investigation to assist with operating costs.

SECTION 3. Section 1 of this act becomes effective December 1, 2016, and applies to offenses committed on or after that date. The remainder of this act becomes effective July 1, 2016.

Drug Fact Sheet

Kratom

Overview

Kratom is a tropical tree native to Thailand, Malaysia, Burma, and other areas of Southeast Asia. Consumption of its leaves produces both stimulant effects (in low doses) and sedative effects (in high doses) and can lead to addiction. The leaves from Kratom trees are widely available on the internet and sold as crushed leaves that can be smoked or steeped for tea and as gel caps.

Street names

Thang, Kakuam, Thom, Ketum, Biak

Looks like

The kratom tree can reach heights of 50 feet with a spread of more than 15 feet. Forms available through the Internet include leaves (whole or crushed), powder, extract, encapsulated powder, and resin "pies," (pellets made from reduced extract).

Methods of abuse

Kratom is mainly abused orally as a tea. Chewing kratom leaves is another method of abuse.

Affect on mind

At low doses, kratom produces stimulant effects with users reporting increased alertness, physical energy, talkativeness, and sociable behavior. At high doses, users experience sedative effects. Effects occur within 5 to 10 minutes of ingestion and last for 2 to 5 hours. Kratom consumption can lead to addiction. Several cases of psychosis resulting from use of kratom have been reported, where individuals addicted to kratom exhibited psychotic symptoms, including hallucinations, delusion, and confusion. Withdrawal effects include symptoms of hostility, aggression, mood swings, runny nose, achy muscles and bones, and jerky movement of the limbs.

Affect on body

Kratom's effects on the body include nausea, itching, sweating, dry mouth, constipation, increased urination, and loss of appetite. Long-term users of kratom have experienced anorexia, weight loss, insomnia, skin darkening, dry mouth, frequent urination, and constipation.

Drugs causing similar effects

The dominant effects of kratom are similar to those of psychostimulant drugs.

Overdose effects

Kratom has been abused as a recreational drug around the world. In low doses, Kratom works as a stimulant and in high doses as a sedative. In low doses (10 grams) kratom induces mild euphoria and reduces fatigue, and generally does not interfere with ordinary activities. With strong doses (20-50 grams) the effects are said to be profoundly euphoric and immensely pleasurable.

Legal status in the United States

Kratom is not controlled under the Controlled Substances Act. There is no legitimate medical use for Kratom in the United States. However, it is marketed on the internet as "alternative medicine" for use as a pain killer, medicine for diarrhea, and other ailments and for the treatment of opiate addiction. Kratom is legal in the United States but is on the DEA list of Drugs and Chemicals of Concern.

Common places of origin

The kratom tree grows in areas of Southeast Asia, but various forms of kratom are widely available on the Internet.

Drug Enforcement Administration
Office of Diversion Control
Drug & Chemical Evaluation Section

KRATOM (*Mitragyna speciosa korth*)
(Street Names: Thang, Kakuam, Thom, Ketum, Biak)

January 2013
DEA/OD/ODE

Introduction:

Kratom, (*Mitragyna speciosa korth*), is a tropical tree indigenous to Thailand, Malaysia, Myanmar and other areas of Southeast Asia. Kratom is in the same family as the coffee tree (*Rubiaceae*). The tree reaches heights of 50 feet with a spread of over 15 feet.

Kratom has been used by natives of Thailand and other regions of Southeast Asia as an herbal drug for decades. Traditionally, kratom was mostly used as a stimulant by Thai and Malaysian laborers and farmers to overcome the burdens of hard work. They chewed the leaves to make them work harder and provide energy and relief from muscle strains. Kratom was also used in Southeast Asia and by Thai natives to substitute for opium when opium is not available. It has also been used to manage opioid withdrawal symptoms by chronic opioid users.

In 1943, the Thai government passed the Kratom Act 2486 that made planting of the tree illegal. In 1979, the Thai government enacted the Narcotics Act B.E. 2522, placing kratom along with marijuana in Category V of a five category classification of narcotics. Kratom remains a popular drug in Thailand. It has been reported that young Thai militants drink a "4x100" kratom formula to make them "more bold and fearless and easy to control." The two "4x100" kratom formulas are described as a mixture of a boiled kratom leaves and mosquito coils and cola or a mixture of boiled cough syrup, kratom leaves and cola served with ice. In this report it was also mentioned use of that the "4x100" formula was gaining popularity among Muslim youngsters in several districts of Yala (Southern Thailand) and was available in local coffee and tea shops.

Kratom is promoted as a legal psychoactive product on numerous websites in the U.S. On those websites, topics range from vendors listings, preparation of tea and recommended doses, to alleged medicinal uses, and user reports of drug experiences.

Licit Uses:

There is no legitimate medical use for kratom in the U.S.

Chemistry and Pharmacology:

Over 25 alkaloids have been isolated from kratom; mitragynine is the primary active alkaloid in the plant.

Pharmacology studies show that mitragynine has opioid-like activity in animals. It inhibits electrically stimulated ileum and vas deferens smooth muscle contraction. Through actions on centrally located opioid receptor, it inhibits gastric secretion and reduces pain response.

Kratom has been described as producing both stimulant and sedative effects. At low doses, it produces stimulant effects, with users reporting increased alertness, physical energy, talkativeness and sociable behavior. At high doses, opiate effects are produced, in addition to sedative and euphoric effects. Effects occur within 5 to 10 minutes after ingestion and last for 2 to 5 hours. Acute side effects include nausea, itching, sweating, dry mouth, constipation, increased urination, and loss of appetite.

Kratom consumption can lead to addiction. In a study of Thai kratom addicts, it was observed that some addicts chewed kratom daily for 3 to 30 years (mean of 18.6 years). Long-term use of kratom produced anorexia, weight loss, insomnia, skin darkening, dry mouth, frequent urination, and constipation. A withdrawal syndrome was observed, consisting of symptoms of hostility, aggression, emotional lability, wet nose, achy muscles and bones, and jerky movement of the limbs. Furthermore, several cases of kratom psychosis were observed, where kratom addicts exhibited psychotic symptoms that included hallucinations, delusion and confusion.

Illicit Uses:

Information on the illicit use of kratom in the U.S. is anecdotal. Based on information posted on the Internet, kratom is mainly being abused orally as a tea. Chewing kratom leaves is another method of consumption. Doses of 2 to 10 grams are recommended to achieve the desired effects. Users report that the dominant effects are similar to those of psychostimulant drugs.

Other countries are reporting emerging new trends in use of kratom. In the United Kingdom, kratom is promoted as an "herbal speedball." In Malaysia, kratom (known as ketum) juice preparations are illegally available.

User Population:

Information on user population in the U.S. is limited. Kratom abuse is not monitored by any national drug abuse surveys.

Illicit Distribution:

The System to Retrieve Information from Drug Evidence (STRIDE), a federal database for the seized drugs analyzed by DEA forensic laboratories, and the National Forensic Laboratory Information System (NFLIS), which collects drug analysis information from state and local forensic laboratories, indicate that there was one drug report of mitragynine, the primary active alkaloid in kratom, in 2010, 44 reports in 2011, and 81 reports in the first six months of 2012. Kratom is widely available on the Internet. There are numerous vendors within and outside of the U.S. selling kratom. Forms of kratom available through the Internet include leaves (whole or crushed), powder, extract, encapsulated powder, and extract resin "pies" (40g pellets made from reduced extract). Seeds and whole trees are also available from some vendors through the Internet, suggesting the possibility of domestic cultivation.

Control Status:

Kratom is not scheduled under the Controlled Substances Act.

Comments and additional information are welcomed by the Drug Chemical Evaluation Section; Fax 202-353-1263, telephone 202-307-7183, or Email ODE@usdoj.gov.

Kratom – Mitragynine(my-trag-e-nine)

National Institute on Drug Abuse

- Kratom comes from a tropical tree (Mitragyna speciosa) native to Southeast Asia, with leaves that contain psychoactive (mind-altering) opioid compounds.
- Primary compounds in Kratom leaves, mitragynine and 7-hydroxymitragynine, both interact with opioid receptors in the brain.
- These compounds produce sedation, pleasure, and decreased pain, There can be dangerous side effects.
- Mitragynine may also interact with other receptor systems in the brain to produce stimulant effects such as increased energy, sociability, alertness and mood enhancing.
- Addiction - Like other opioid drugs, Kratom may cause dependence (feeling physical withdrawal symptoms when not taking the drug), and some users have reported becoming addicted to Kratom.
- Illegal in Thailand since Kratom Act 2486 of 1943 making the tree that produces Kratom leaves illegal.

- Drug Enforcement Administration – ***"There is no legitimate medical use for Kratom in the U.S."*** & listed as drug of concern.

Purchasing & Use

- Widely available online. Shops, gas stations, and convenient stores sale it.
- Local bars/coffee shops sell it in drinks such as tea.
- Methods of abuse – the leaves may be chewed, or used in a tea. The leaves are also ground into a powder and used in tea, coffee or smoothies.
- Kratom is used in energy drinks, powders, teas, pills, smoked, vapors, basically any form you want. Mixing powders seems to be most common.

Health Risks

- "We have identified Kratom as a botanical substance that could pose a risk to public health and have the potential for abuse," said Melinda Plaisier, the FDA's associate commissioner for regulatory affairs.
- Serious concerns exist regarding the toxicity of Kratom in multiple organ systems. Consumption of Kratom can lead to a number of health impacts, including, among others, respiratory depression, vomiting, nervousness, weight loss and constipation. - U.S. Food and Drug Administration
- Long term affects – anorexia, weight loss, insomnia, skin darkening, dry mouth, frequent urination, and constipation.
- Withdrawal symptoms include: - National Institute on Drug Abuse

  - muscle aches
    Insomnia
  - irritability
  - hostility
  - aggression
  - emotional changes
  - runny nose
  - jerky movements

Other Legislation

- The U.S. Department of Justice, on behalf of the FDA, filed a complaint alleging, among other things, that Kratom is a new dietary ingredient for which there is inadequate information to provide reasonable assurance that it does not present a significant or unreasonable risk of illness or injury; therefore, dietary supplements containing Kratom are adulterated under the FD&C Act. – US Food and Drug Administration
- Banned in 6 states –
  - Alabama
  - Arkansas
  - Indiana
  - Tennessee
  - Vermont
  - Wisconsin
- Only legal for adults over age of 18 - New Hampshire & Illinois
- Florida (vote failed), Georgia(bill removed), Louisiana (language changed to remove Kratom ban), Michigan legislation (not passed in 2014), Oklahoma (not passed in 2014)

Provided by NC Medical Examiner's Office chief toxicologist:

Total cases positive for mitragynine : 23
First case in NC: June 13, 2012
Latest case in NC: April 1,2016
Cases per year:
2012-1
2013-1
2014-7
2015-8
2016-6 (so far)

Average age of decedent: 36 years
Range of age: 24-49

Manner of death:
Accident-14
Suicide-1
Homicide-2
Pending-6

Means of Death:
Gunshot wound-2
Asphyxiation-1
Pending-6
Poisoning with Mitragynine- 14**

**plus or minus other drugs including heroin, fentanyl, alprazolam, clonazepam and ethan

SENATE BILL 838:
Medicaid Transformation Modifications.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	May 17, 2016
Introduced by:	Sen. Hise	**Prepared by:**	Jennifer Hillman
Analysis of:	PCS to First Edition S838-CSTR-8		Staff Attorney

SUMMARY: ***The PCS to Senate bill 838 would require additional reporting on the status of Medicaid transformation planning and implementation and would make modifications proposed by the Department of Health and Human Services (DHHS) to the 2015 Medicaid Transformation session law.***

CURRENT LAW: S.L. 2015-245, An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs, became law on September 23, 2015, and provided a legislative framework for the transformation of North Carolina's Medicaid program to provide budget predictability for the taxpayers of the State while ensuring quality care to those in need. S.L. 2015-245 requires transition of the current Medicaid and NC Health Choice programs to capitated contracts with Prepaid Health Plans (PHPs) under an 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS). S.L. 2015-245 also created the Division of Health Benefits (DHB) within the Department of Health and Human Services (DHHS) to plan for and implement for transformation established by the General Assembly.

BILL ANALYSIS: **Section 1** of the PCS would require DHHS to submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (Medicaid Oversight Committee) by October 1, 2016 containing an update on the status of the 1115 waiver submission and responses received from CMS, a detailed Work Plan identifying key milestones, tasks, and events necessary to the transition of the programs, and a description of any other changes relevant to successful implementation of the Medicaid and NC Health Choice transformation. The language in this section was recommended by the Medicaid Oversight Committee in its April 2016 report.

Section 2 of the PCS makes changes proposed by DHHS in its March 1, 2016 report to the Medicaid Oversight Committee. Throughout Section 2, the PCS strikes references that DHHS must act "through the DHB" in conducting activities related to Medicaid transformation. Certain references to the DHB alone are replaced with references to DHHS, clarifying that authority and responsibility in those instances are at the Department level.

Section 2(b) amends subdivisions (4), (5), and (6) of Section 4 of S.L. 2015-245 to add certain services to the list of services excluded from PHP coverage, add populations to the list of populations excluded from PHP coverage, and increase the maximum number of provider-led entities (PLEs) allowed to enter into a regional PHP contract from 10 to 12. **Section 2(f)** clarifies that, until the procedures for appointing the Director of the Division of Health Benefits in G.S. 143B-216.85 become effective in 2021, DHHS has authority to hire the Director of the Division of Health Benefits. **Sections 2(g) and 2(h)** codify language that was uncodified in S.L. 2015-245 and move language that was previously codified in G.S. 108A-54(g) to G.S. 143B-216.80. **Section 2(i)** clarifies the definition of "administration

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Director

Legislative Analysis Division
919-733-2578

of a contract" and "former employee of the Department" in G.S. 143B-139.6C, which was enacted as part of S.L. 2015-245 and imposes a cooling-off period for certain Department employees.

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

BACKGROUND: As required by S.L. 2015-245, DHHS, through the DHB, submitted a report to the Medicaid Oversight Committee on March 1, 2016 that described its proposed statutory changes necessary to implement the Medicaid transformation plan. In its April 2016 report, the Medicaid Oversight Committee recommended that the General Assembly consider the legislative changes proposed in DHHS's report and further requested in a special provision to the 2016 Governor's Budget. A copy of the report is available at: http://www.ncleg.net/documentsites/committees/BCCI-6660/Final%20LOC%20Reports%20to%20the%20GA/Medicaid%20Oversight%20Committee%20Report%20April%202016_FINAL.pdf

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S D

SENATE BILL 838
PROPOSED COMMITTEE SUBSTITUTE S838-CSTR-8 [v.5]
05/16/2016 02:16:37 PM

Short Title: Medicaid Transformation Modifications. (Public)

Sponsors:

Referred to:

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE FURTHER REPORTING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO TRANSFORMATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS AND TO MODIFY CERTAIN PROVISIONS OF THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

SECTION 1. No later than October 1, 2016, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division containing the following items:

(1) The status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation. The report shall specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.

(2) A detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan shall identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan shall specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event.

(3) A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Health Choice transformation.

SECTION 2.(a) Section 3 of S.L. 2015-245 reads as rewritten:

"**SECTION 3.** Time Line for Medicaid Transformation. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. –

a. The Division of Health Benefits of the Department of Health and Human Services (DHHS) is created pursuant to Section 10 of this act.

b. The Joint Legislative Oversight Committee on Medicaid and NC Health Choice is created pursuant to Section 15 of this act to oversee the Medicaid and NC Health Choice programs.

c. ~~The Division of Health Benefits~~ DHHS shall begin development of the 1115 waiver and any other State Plan amendments and waiver amendments necessary to effectuate the Medicaid transformation required by this act.

(2) March 1, 2016. – ~~The DHHS, through the Division of Health Benefits,~~ DHHS shall report its plans and progress on Medicaid transformation, including recommended statutory changes, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, as required by subdivision (12) of Section 5 of this act.

(3) On or before June 1, 2016. – ~~The DHHS, through the Division of Health Benefits~~ DHHS shall submit the waivers and State Plan amendments required by this act to the Centers for Medicare & Medicaid Services (CMS).

(4) Eighteen months after approval of all necessary waivers and State Plan amendments by CMS. – Capitated contracts shall begin and initial recipient enrollment shall be complete."

SECTION 2.(b) Section 4 of S.L. 2015-245 reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

(1) DHHS authority. – The Department of Health and Human Services (DHHS) shall have full authority to manage the State's Medicaid and NC Health Choice programs provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program, except the General Assembly shall determine eligibility categories and income thresholds. DHHS ~~through the Division of Health Benefits, created in Section 10 of this act,~~ shall be responsible for planning and implementing the Medicaid transformation required by this act.

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) ~~shall be excluded from the capitated contracts~~ until four years after the date capitated contracts begin.

b. ~~The capitated contracts required by this subdivision shall not cover~~ ~~dental~~Dental services.

c. Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

d. Audiology, speech therapy, occupational therapy, physical theray, nursing and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individual contracted with Local Education Agencies.

e. Services provided pursuant to a contract with a Children's Developmental Services Agencies.

f. Services for Medicaid program applicants during the three-month retroactive eligibility period authorized by 42 U.S.C. 1396a(a)(34). Services provided during a prospective, 12-month continuous enrollment period shall be covered by the capitated contracts.

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except ~~recipients~~ for the following categories:

a. Recipients who are dually eligible for Medicaid and Medicare. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.

b. Qualified aliens subject to the 5-year bar for means-tested public assistance under 8 U.S.C. 1613 who qualify for emergency services under 8 U.S.C. 1611.

c. Undocumented aliens who qualify for emergency services under 8 U.S.C. 1611.

d. Medically needy Medicaid recipients.

e. Members of federally-recognized tribes. Members of federally-recognized tribes shall have the option to enroll voluntarily in PHPs.

f. Presumptively eligible recipients, during the period of presumptive eligibility. Presumptively eligible recipients who submit a full Medicaid application and are determined eligible for the Medicaid program shall be covered by capitated contracts during the prospective, 12-month continuous enrollment period after they have been determined eligible.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. Three contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to ~~10~~ 12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

...."

SECTION 2.(c) Section 5 of S.L. 2015-245 reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of ~~DHHS, through the Division of Health Benefits,~~ DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All

contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. ~~DHHS, through the Division of Health Benefits,~~ DHHS shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by ~~DHHS, through the Division of Health Benefits.~~DHHS.

c. Until final federal regulations are promulgated governing medical loss ratio, a minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by ~~DHHS, through the Division of Health Benefits.~~DHHS.

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(11) Develop a Dual Eligibles Advisory Committee, which must include at least a reasonably representative sample of the populations receiving long-term services and supports covered by Medicaid. ~~The Division of Health Benefits,~~DHHS, upon the advice of the Dual Eligibles Advisory Committee, shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts and report the strategy to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 31, 2017.

...

(13) Designate Medicaid and NC Health Choice providers as essential providers if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice recipients within the region during the last three years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. DHHS shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

a. Federally qualified health centers.

b. Rural health centers.

c. Free clinics.

d. Local health departments.
e. State Veterans Homes"

SECTION 2.(d) Section 8 of S.L. 2015-245 reads as rewritten:

"**SECTION 8.** Innovations Center. – DHHS shall submit a program design and budget proposal no later than May 1, 2016, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice that will create a Medicaid and NC Health Choice Transformation Innovations Center ~~within the Division of Health Benefits~~ with the purpose of assisting Medicaid and NC Health Choice providers in achieving the ultimate goals of better health, better care, and lower costs for North Carolinians. The center should be designed to support providers through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. DHHS shall use the Oregon Health Authority's Transformation Center as a design model and shall consider at least the following features:

(1) Learning collaboratives, peer-to-peer networks.
(2) Clinical standards and supports.
(3) Innovator agents.
(4) Council of Clinical Innovators.
(5) Community and stakeholder engagement.
(6) Conferences and workshops.
(7) Technical assistance.
(8) Infrastructure support."

SECTION 2.(e) Section 9 of S.L. 2015-245 reads as rewritten:

"**SECTION 9.** Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this act, ~~the Department of Health and Human Services, through the Division of Health Benefits created in Section 10 of this act,~~DHHS shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then ~~the Division of Health Benefits~~DHHS shall advise the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, created in Section 15 of this act, of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals."

SECTION 2.(f) Section 10 of S.L. 2015-245 reads as rewritten:

"**SECTION 10.** Creation of the Division of Health Benefits. – The Division of Health Benefits is established as a new division of the Department of Health and Human Services. ~~The Department of Health and Human Services, through the Division of Health Benefits, shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs.~~ The Division of Medical Assistance shall continue to operate the current Medicaid and NC Health Choice programs until the Division of Medical Assistance is eliminated. Upon the elimination of the Division of Medical Assistance, all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance of the Department of Health and Human Services are vested in the Division of Health Benefits. The Department of Health and Human Services shall remain the Medicaid single State ~~agency.~~ agency and shall be responsible for implementing Medicaid transformation required by this act and shall administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Helath Choice programs. Prior to the effective date of G.S. 143B-216.85, the Secretary of DHHS may appoint a Director of the Division of Health Benefits."

SECTION 2.(g) G.S. 143B-216.80 reads as rewritten:

"**§ 143B-216.80. Division of Health Benefits – creation and organization.**

(a) There is hereby established the Division of Health Benefits of the Department of Health and Human Services. The Director shall be the head of the Division of Health Benefits. Upon the elimination of the Division of Medical Assistance, the Division of Health Benefits shall be vested with all functions, powers, duties, obligations, and services previously vested in the Division of Medical Assistance. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the powers and duties described in G.S. ~~108A-54(e). The Director shall be the head of the Division of Health Benefits.~~ 108A-54(e) in addition to the powers and duties already vested in the Department.

(b) Although generally subject to the laws of this State, the following exemptions, limitations and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:

(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.

(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but still may choose to utilize the State contract review and approval procedures for particular contracts."

SECTION 2.(h) G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

...

(e) The Department of Health and Human Services shall continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits. Prior to and following the exchange of powers and duties from the Division of Medical Assistance to the Division of Health Benefits, and in addition to the powers and duties already vested in the Secretary of the Department of Health and Human Services, the Secretary of the Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for each program. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ clerical and professional staff of the Division of Health Benefits, including consultants and legal counsel, necessary to carry out the powers and duties of the division. In hiring staff for the Division of Health Benefits, the Secretary may offer employment contracts for a term and set compensation for the employees, which may include performance-based bonuses based on meeting budget or other targets.

(3) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(4) Establish and adjust all program components, except for eligibility categories and income thresholds, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.
(5) Adopt rules related to the Medicaid and NC Health Choice programs.
(6) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.
(7) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.
(8) Develop and present to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Office of State Budget and Management by January 1 of each year, beginning in 2017, the following information for the Medicaid and NC Health Choice programs:
a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.
b. What program changes will be made by the Department in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.
c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.
(9) Publish on its Web site and update on at least a monthly basis, at a minimum, the following information about the Medicaid and NC Health Choice programs:
a. Enrollment by program aid category by county.
b. Per member per month spending by category of service.
c. Spending and receipts by fund along with a detailed variance analysis.
d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(f) The General Assembly shall determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The Department of Health and Human ~~Services, through the Division of Health Benefits,~~ Services is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with the parameters set by the General Assembly.

~~(g) Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Division of Health Benefits of the Department of Health and Human Services, notwithstanding any other provision of law:~~
~~(1) Employees of the Division of Health Benefits shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).~~
~~(2) The Secretary may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).~~
~~(3) The Division of Health Benefits' employment contracts offered pursuant to G.S. 108A-54(e)(2) are not subject to review and approval by the Office of State Human Resources.~~
~~(4) If the Secretary establishes alternative procedures for the review and approval of contracts, then the Division of Health Benefits is exempt from State contract review and approval requirements but may still choose to utilize the State contract review and approval procedures for particular contracts.~~"

SECTION 2.(i) G.S. 143B-139.6C reads as rewritten:

"**§ 143B-139.6C. Cooling-off period for certain Department employees.**

(a) Ineligible Vendors. – The Secretary of the Department of Health and Human Services shall not contract for goods or services with a vendor that employs or contracts with a person who

is a former employee of the Department and uses that person in the administration of a contract with the Department.

(b) Vendor Certification. – The Secretary shall require each vendor submitting a bid or contract to certify that the vendor will not use a former employee of the Department in the administration of a contract with the Department in violation of the provisions of subsection (a) of this section.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – ~~Oversight~~The former employee's duties and responsibilities for the vendor include oversight of the performance of a contract, or authority to make decisions regarding a contract, including interpretation of a contract, ~~or participation in the~~ development of specifications or terms of a ~~contract or in the preparation~~ contract, or award of a contract.

(2) Former employee of the Department. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Department of Health and Human ~~Services, and in the six months immediately preceding termination of State employment, participated personally in either the award or management of a Department contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.~~ Services and personally participated in any of the following:

a. The award of a contract to the vendor.

b. An audit, decision, investigation, or other action affecting the vendor.

c. Regulatory or licensing decisions that applied to the vendor."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

SENATE BILL 838*

Short Title:	Medicaid Transformation Reporting.	(Public)
Sponsors:	Senators Hise (Primary Sponsor); Cook, Pate, and Sanderson.	
Referred to:	Health Care	

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO REQUIRE FURTHER REPORTING FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RELATED TO TRANSFORMATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MEDICAID AND NC HEALTH CHOICE.

The General Assembly of North Carolina enacts:

SECTION 1. No later than October 1, 2016, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division containing the following items:

(1) The status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation. The report shall specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.

(2) A detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan shall identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan shall specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event.

(3) A sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Health Choice transformation.

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

SENATE BILL 841:
Medicaid Eligibility Timeliness/Funds.

2016-2017 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget	**Date:**	May 17, 2016
Introduced by:	Sens. Hise, Krawiec, Foushee	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

SUMMARY: Senate bill 841 would enact provisions to support improvement in the timeliness of Medicaid eligibility determinations by county departments of social services (DSSs).

CURRENT LAW: Medicaid eligibility determinations are conducted by county DSSs pursuant to G.S. 108A-14. Federal Medicaid regulation 42 C.F.R. 435.912 requires the State Medicaid program to meet certain timeliness standards as well as establish performance standards for the timely processing of Medicaid applications.

BILL ANALYSIS: Section 1 of the bill would require a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Joint Legislative Oversight Committee on Health and Human Services by November 1, 2016 and November 1, 2017 containing data related to the timeliness of Medicaid eligibility determinations for the preceding fiscal year.

Section 2(a) of the bill would create a new Part 10 in Article 2 of Chapter 108A of the General Statutes establishing procedures for ensuring Medicaid eligibility decision processing timeliness. These new statutes address timeliness standards, monitoring requirements, corrective action requirements, and authority for the Department of Health and Human Services (DHHS) to temporarily assume the county DSS's Medicaid eligibility administration function if corrective action is unsuccessful. The new statutes apply to any Native American tribe that conducts Medicaid eligibility determinations in the same manner they apply to county DSSs.

New G.S. 108A-70.32 requires county DSSs to adhere to the timely decision standards required by federal regulations.

New G.S. 108A-70.33 through 108A-70.35 set forth the timely processing standards that DHHS will use to monitor timeliness. The timely processing standards are average processing time and percentage processed timely, and these standards are calculated on a monthly basis. The timely processing standards are based on standards that are currently in rule or DHHS policy.

New G.S. 108A-70.36 sets forth procedures for corrective action. If a county DSS does not meet either the average processing time standard or the percentage processed timely standard for any three consecutive months or five out of any 12 consecutive months, then DHHS and the county DSS shall enter into a joint corrective action plan to improve the timely processing of applications. This trigger for corrective action is currently in rule. The joint corrective action plan cannot exceed 12 months; however, if a county DSS shows measureable progress during the initial period of the joint corrective action plan, the period for completion of the plan may be extended by six months. The joint corrective action plan must describe the actions to be taken by the county DSS and DHHS, the performance requirements that constitute successful completion of the plan, and an acknowledgement that failure to successfully complete the plan will result in DHHS temporarily assuming Medicaid eligibility administration.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

New G.S. 108A-70.37 sets forth procedures for DHHS's temporary assumption of Medicaid eligibility administration. If the county DSS fails to successfully complete the joint correction action plan, then DHHS must give at least 90 days' notice of intent to temporarily assume Medicaid eligibility administration. The notice must state the date of intended assumption, identify the performance requirements in the joint corrective action plan that the county DSS failed to meet, and advise of the right to appeal the decision to the Office of Administrative Hearings. During a period of temporary assumption of Medicaid eligibility administration, DHHS will administer the Medicaid eligibility function in the county, the county DSS will be divested of its administration authority, DHHS will direct and oversee the expenditure of funding for Medicaid eligibility administration, and the county shall continue to pay the nonfederal share of the cost of Medicaid eligibility administration, including additional costs incurred to ensure timely processing of applications. In addition, DHHS will work with the county DSS to develop a plan for the county DSS to resume Medicaid eligibility administration and shall keep the county stakeholders informed about key activities and ongoing concerns. Temporary assumption of Medicaid eligibility administration will be terminated when DHHS determines that the county DSS can make timely eligibility decisions based on the performance standards set out in statute, and upon notice to the county DSS.

Section 2(b) of the bill states that a county's appeal of DHHS's decision to temporarily assume Medicaid eligibility administration may be filed as a contested case at the Office of Administrative Hearing.

Section 2(c) of the bill states that the corrective action procedures previously established in rule are superseded by the new corrective action procedures established in statute.

Section 3 of the bill would appropriate a total of $300,000 to fund a total of 7 new positions within DHHS to support better utilization of data from NC FAST, the IT system that is used for Medicaid eligibility determinations, and better performance measurement and evaluation of Medicaid eligibility determinations. Of these 7 positions, 3 are new Business System Analyst positions and 4 are new Human Services Evaluator/Planner positions. The state funding for these positions will receive federal matching funds to cover the full cost of the positions.

EFFECTIVE DATE: The procedures for corrective action and temporary assumption of Medicaid eligibility administration would become effective January 1, 2017, and would apply to monthly timely processing standards beginning on that date. The remainder of the bill would become effective July 1, 2016.

BACKGROUND: In Report Number 2016-04, "Timeliness of Medicaid Eligibility Determinations Declined Due to Challenges Imposed by NC FAST and Affordable Care Act Implementation" (April 11, 2016), the Program Evaluation Division presented recommendations to support improvement in the timeliness of Medicaid eligibility determinations by county DSSs. The recommendations proposed in the report are the basis for this bill. A copy of the report is available at: http://www.ncleg.net/PED/Reports/2016/MedicaidEligibility.html.

SENATE BILL 841:
Medicaid Eligibility Timeliness/Funds.

2016-2017 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget	**Date:**	May 17, 2016
Introduced by:	Sens. Hise, Krawiec, Foushee	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

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Karen Cochrane-Brown
Director

S841-SMTR-19 E1 -V-3

Legislative Analysis Division
919-733-2578

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Section 2(b) of the bill states that a county's appeal of DHHS's decision to temporarily assume Medicaid eligibility administration may be filed as a contested case at the Office of Administrative Hearing.

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EFFECTIVE DATE: The procedures for corrective action and temporary assumption of Medicaid eligibility administration would become effective January 1, 2017, and would apply to monthly timely processing standards beginning on that date. The remainder of the bill would become effective July 1, 2016.

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SENATE BILL 841*

Short Title:	Medicaid Eligibility Timeliness/Funds.	(Public)
Sponsors:	Senators Hise, Krawiec, Foushee (Primary Sponsors); and Pate.	
Referred to:	Health Care	

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO SUPPORT IMPROVEMENT IN THE TIMELINESS OF MEDICAID ELIGIBILITY DETERMINATIONS, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance (DHHS), shall submit a report annually for the 2015-2016 and 2016-2017 fiscal year to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division containing the following information:

(1) The annual statewide percentage of Medicaid applications processed in a timely manner for the fiscal year.

(2) The statewide average number of days to process Medicaid applications for each month in the fiscal year.

(3) The annual percentage of Medicaid applications processed in a timely manner by each county department of social services for the fiscal year.

(4) The average number of days to process Medicaid applications for each month for each county department of social services.

(5) The number of months during the fiscal year that each county department of social services met the timely processing standards in Part 10 of Article 2 of Chapter 108A of the General Statutes.

(6) The number of months during the fiscal year that each county department of social services failed to meet the timely processing standards in Part 10 of Article 2 of Chapter 108A of the General Statutes.

(7) A description of all corrective action activities conducted by DHHS and county departments of social services in accordance with G.S. 108A-70.36.

(8) A description of how DHHS plans to assist county departments of social services in meeting timely processing standards for Medicaid applications, for every county in which the performance metrics for processing Medicaid applications in a timely manner do not show significant improvement compared to the previous fiscal year.

The report for the 2015-2016 fiscal year shall be submitted by November 1, 2016, and the report for the 2016-2017 fiscal year shall be submitted by November 1, 2017.

SECTION 2.(a) Article 2 of Chapter 108A of the General Statutes is amended by adding a new Part to read:

"Part 10. Medicaid Eligibility Decision Processing Timeliness.

"**§ 108A-70.31. Applicability.**

If a federally recognized Native American tribe within the State has assumed responsibility for the Medicaid program pursuant to G.S. 108A-25(e), then this Part applies to the tribe in the same manner as it applies to county departments of social services.

"**§ 108A-70.32. Timely decision standards.**

The county department of social services shall render a decision on an individual's application for Medicaid within 45 calendar days from the date of application, except for applications in which a disability determination has already been made or is needed. For those applications, the county department of social services shall render a decision on an individual's eligibility within 90 calendar days from the date of application.

"**§ 108A-70.33. Timely processing standards.**

(a) The Department shall require counties to comply with timely processing standards. The timely processing standards are the average processing time standards and the percentage processed timely standards set forth in G.S. 108A-70.34 and G.S. 108A-70.35. The Department shall monitor county department of social services' compliance with these standards in accordance with this Part.

(b) For purposes of this Part, processing time is the number of days between the date of application and the date of disposition of the application, except in cases where an eligibility determination is dependent upon receipt of information related to one or more of the following:

(1) Medical expenses sufficient to meet a deductible.
(2) The applicant's need for institutionalization.
(3) The applicant's plan of care for the home- and community-based waivers.
(4) The disability decision made by the Disability Determination Services Section of the Division of Vocational Rehabilitation of the Department.
(5) Medical records needed to determine emergency dates for nonqualified aliens.
(6) The applicant's application or other information from the federally facilitated marketplace.
(7) The applicant's application or other information in connection with an application for a Low Income Subsidy for Medicare prescription drug coverage.

In these cases, processing time shall exclude the number of days between the date when the county determines all eligibility criteria other than the criteria in subdivisions (1) through (7) of this subsection and the date when the county receives the information related to the criteria in subdivisions (1) through (7) of this subsection.

(c) Processing times for the following types of cases shall be excluded from the calculation of the average processing time and percent processed timely:

(1) Newborns who are automatically enrolled based on their mother's eligibility.
(2) Applications for individuals who are presumptively eligible for Medicaid.
(3) Active cases in which an individual who is eligible for one program is transferred to another program, regardless of whether the transfer occurs between allowable or nonallowable program categories.
(4) Cases in which an individual transfers from an open case to another case, including establishing a new administrative case for the individual.
(5) Actions to post eligibility to a terminated or denied case within one year of the termination or denial.
(6) Cases that are reopened because they were terminated in error or because reopening of the terminated case is allowed by policy.
(7) Cases in which the eligibility decision was appealed and the decision was reversed or remanded.

(d) The Department may, in its discretion, exclude days, other than those required by subsection (b) of this section, from the calculation of processing time under this section if the Department determines that the delay was caused by circumstances outside the control of county

departments of social services. The Department also may, in its discretion, exclude types of cases, other than those described in subsection (c) of this section, from the calculation of processing time. When the Department exercises its discretion pursuant to this subsection, the Department's determination regarding circumstances outside the control of county departments of social services and the Department's decision to exclude types of cases shall be applied uniformly to all county departments of social services.

"**§ 108A-70.34. Average processing time standards.**

(a) Average processing time is calculated by finding the processing time for each case that received a disposition during a given month and finding the average of those processing times.

(b) The standard for average processing time is 90 days for cases in which the individual has applied for the Medicaid Aid to the Disabled category (M-AD) and 45 days for all other cases.

"**§ 108A-70.35. Percentage processed timely standards.**

(a) Percentage processed timely is the percentage of cases that received a timely disposition in a given month. The percentage processed timely is calculated by expressing the number of cases during a given month with a processing time equal to or less than the standard set in G.S. 108A-70.32 as a percentage of the total cases receiving a disposition during that month. When the deadline for meeting the timely decision standard in G.S. 108A-70.32 falls on a weekend or holiday, an application that receives a disposition on the first workday following the deadline shall be considered timely for purposes of calculating the percentage processed timely.

(b) The Department is authorized to adopt rules to establish a percentage standard for each county department of social services that will be the percentage processed timely standard for that county department of social services. Until the Department adopts rules establishing percentage standards for each county, the percentage processed timely standards are those established in 10A NCAC 23C .0203 as of April 2016.

"**§ 108A-70.36. Corrective action.**

(a) If for any three consecutive months or for any five months out of a period of 12 consecutive months a county department of social services fails to meet either the average processing time standard or the percentage processed timely standard or both standards, the Department and the county department of social services shall enter into a joint corrective action plan to improve the timely processing of applications.

(b) A joint corrective action plan entered into pursuant to this section shall specifically identify the following components:

(1) The duration of the joint corrective action plan, not to exceed 12 months. If a county department of social services shows measurable progress in meeting the performance requirements in the joint corrective action plan, then the duration of the joint corrective action plan may be extended by six months, but in no case shall a joint corrective action plan exceed 18 months.

(2) A plan for improving timely processing of applications that specifically describes the actions to be taken by the county department of social services and the Department.

(3) The performance requirements for the county department of social services that constitute successful completion of the joint corrective action plan.

(4) Acknowledgement that failure to successfully complete the joint corrective action plan will result in temporary assumption of Medicaid eligibility administration by the Department, in accordance with G.S. 108A-70.37.

"**§ 108A-70.37. Temporary assumption of Medicaid eligibility administration.**

(a) If a county department of social services fails to successfully complete its joint corrective action plan, the Department shall give the county department of social services, the county manager, and the board of social services or the consolidated human services board created pursuant to G.S. 153A-77(b) at least 90 days' notice that the Department intends to temporarily

assume Medicaid eligibility administration, in accordance with subsection (b) of this section. The notice shall include the following information:

(1) The date on which the Department intends to temporarily assume administration of Medicaid eligibility decisions.

(2) The performance requirements in the joint corrective action plan that the county department of social services failed to meet.

(3) Notice of the county department of social services' right to appeal the decision to the Office of Administrative Hearings, pursuant to Article 3 of Chapter 150B of the General Statutes.

(b) Notwithstanding any provision of law to the contrary, if a county department of social services fails to successfully complete its joint corrective action plan, the Department shall temporarily assume Medicaid eligibility administration for the county upon giving notice as required by subsection (a) of this section. During a period of temporary assumption of Medicaid eligibility administration, the following shall occur:

(1) The Department shall administer the Medicaid eligibility function in the county. Administration by the Department may include direct operation by the Department, including supervision of county Medicaid eligibility workers, or contracts for operation to the extent permitted by federal law and regulations.

(2) The county department of social services is divested of Medicaid administration authority.

(3) The Department shall direct and oversee the expenditure of all funding for the administration of Medicaid eligibility in the county.

(4) The county shall continue to pay the nonfederal share of the cost of Medicaid eligibility administration and shall not withdraw funds previously obligated or appropriated for Medicaid eligibility administration.

(5) The county shall pay the nonfederal share of additional costs incurred to ensure compliance with the timely processing standards required by this Part.

(6) The Department shall work with the county department of social services to develop a plan for the county department of social services to resume Medicaid eligibility administration and perform Medicaid eligibility determinations in a timely manner.

(7) The Department shall inform the county board of commissioners, the county manager, the county director of social services, and the board of social services or the consolidated human services board created pursuant to G.S. 153A-77(b) of key activities and any ongoing concerns during the temporary assumption of Medicaid eligibility administration.

(c) Upon the Department's determination that Medicaid eligibility determinations can be performed in a timely manner based on the standards set forth in G.S. 108A-70.34 and G.S. 108-70.35 by the county department of social services, the Department shall notify the county department of social services, the county manager, and the board of social services or the consolidated human services board created pursuant to G.S. 153A-77(b) that temporary assumption of Medicaid eligibility administration will be terminated and the effective date of termination. Upon termination, the county department of social services resumes its full authority to administer Medicaid eligibility determinations."

SECTION 2.(b) G.S. 150B-23 is amended by adding a new subsection to read:

"(a5) A county that appeals a decision of the Department of Health and Human Services to temporarily assume Medicaid eligibility administration in accordance with G.S. 108A-70.37 may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases under this Article."

SECTION 2.(c) The corrective action procedures described in this section supersede the corrective actions procedures in 10A NCAC 23C .0204 and 10A NCAC 23C .0205 related to timeliness processing of Medicaid applications by county departments of social services.

SECTION 3.(a) There is appropriated to the Department of Health and Human Services, Division of Central Management and Support, for the 2016-2017 fiscal year the sum of one hundred forty-three thousand two hundred fifteen dollars ($143,215) in recurring funds to be used to fund three new Business System Analyst positions within the Operational Support Team under the Assistant Secretary of Human Services. These funds shall provide a State match for an estimated one hundred forty-three thousand two hundred fifteen dollars ($143,215) in recurring federal funds in the 2016-2017 fiscal year, and those federal funds are hereby appropriated to be used for the same purpose.

SECTION 3.(b) There is appropriated to the Department of Health and Human Services, Division of Social Services, for the 2016-2017 fiscal year the sum of one hundred fifty-six thousand seven hundred eighty-five dollars ($156,785) in recurring funds to be used to fund four new Human Services Evaluator/Planner positions within the Performance Management Section of the Division of Social Services. These funds shall provide a State match for an estimated one hundred fifty-six thousand seven hundred eighty-five dollars ($156,785) in recurring federal funds in the 2016-2017 fiscal year, and those federal funds are hereby appropriated to be used for the same purpose.

SECTION 4. The Department of Health and Human Services may adopt and amend rules to implement Section 2 of this act.

SECTION 5. Section 2 of this act becomes effective January 1, 2017, and applies to monthly timely processing standards beginning on that date. The remainder of this act becomes effective July 1, 2016.

Senate Pages Attending

COMMITTEE: Health Care ROOM: 544

DATE: 5-17 TIME: 11 AM

PLEASE PRINT <u>LEGIBLY</u>!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Drew Fisher	Mooresville, NC	Curtis
2. ~~Noah~~ Noah de ~~Hoorde~~ Comarmond	Raleigh	Chaudhuri
3. Anna Blount	Clinton	B. Jackson
4. Jennifer Qian (Chen)	Chapel Hill, NC	Woodard
5. Kate Taylor	Wilson, NC	Newton
6. Sanaa Lucas	Winston, NC	Come
7. Hunter Smith	Mocksville, NC	~~Brooks~~ Brook
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.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

Health Care

May 17, 2016

11:00 AM

Senate Sergeant at Arms

Frances Patterson

Hal Roach

Matt Urben

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — May 17, 2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Lori Kroll	Novant Health
Tony Adams	Adams and Assoc.
DAVID POWERS	WCSR
Betsy McCorkle	SSGNC
Judy Jenkins	Otsuka
[illegible]	NCALTCF
Amy Ellen	NCRMA
Mike Jones	DCP
Tracy Kimbrell	Parker Poe
LAURA PURYEAR	LAURIE ONORIO, LLC
David Hansen	NC Center for Nonprofits

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — May 17, 2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
John McMillan	MFHS
Phoebe Landen	MUSC
Alyssa Levine	NCAWA
Sonya Linton	NCAWA
Ashley Perkins	Perkins Law
Kelsey Byerly	Laurel Ohario, LLC
Sarah Sanger	NP
Christine Craig	WakeMed
Ryan Blackledge	Core Health
Cody Hand	NC HIA
Lanier Hodgson	UNC Health Care

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — May 17, 2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Brian Capps	Office of the Gov.
Gerry Cohen	Nelson Mullins
Mary Gooden	GSK
Keely Flow/Andrew Runge	Novo Nova
Dave Richard	DHHS
Dee Jones	DHHS
Ken Melvin	Benchmarks
Lisa Martin	Cap-Ad
Michael Watson	SANDHILLS GMG

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — May 17, 2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Gretchen Kelly	FirstHealth
[illegible]	UNC
Kelly Vogel	KV strategics.
Amanda Donovan	TSS
NIATOULE KARIM	NAMI NC
Emily Callen	PPSAT
[illegible] Forbes	Forbes for NC Senate 2016
Dr. Zachary Horn	NC Ag-
[illegible]	R. [illegible]
Chris McDaniel	ICTS
Chris Jones	Office of The Governor

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — May 17, 2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Fred Baer	Baer AWD
Adam Shaw	NCHCFA
Amy R	Kilpatrick
Dodie Renfer	CCR
Melissa Peterson	CCR
Carolyn McClanahan	DMA

VISITOR REGISTRATION SHEET

Senate Committee on Health Care — May 17, 2016

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Hugh Jones	NCAE
Jeff Moore	North State Journal
Peggy Mazur	
Stacy Yancey	NCANA
Darcy Bennett-Harwood	NCANA
	DC1
Thom Goolsby	
	NMFS
Elizabeth Gardner	Krave CH, LLC 105 W Main St Carrboro, NC 27278
Russell Bowen	Self resident + voter SB830

Senate Committee on Health Care
Tuesday, June 14, 2016 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 14, 2016, in Room 544 of the Legislative Office Building. Fifteen members were present.

Senator Louis Pate, Chair, presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms for the meeting: Larry Hancock, Sham Patel and Becky Myrick. He also recognized the following Pages assisting with the meeting: Amy Clemmons, Greear Webb, Owen Tierney, III and Griffin Sullivan all of Raleigh; Kelly Anne Faulk of Sanford, Hogan Disbrow of Southport, Jordyn Scheitler of Belmont, Seth Norwood of Greensboro and Will Pruthi of Durham.

Senator Hise was recognized to explain HB 1014, "NC Pre-K Conforming Change/Taylor's Law." Senator Woodard motioned for the bill to receive a Favorable Report; motion carried.

Senator Pate then recognized Representative Bert Jones to explain HB 1145 "Disapprove Dental Examiners Rule." A motion was made by Senator Don Davis for a Favorable Report; motion carried.

HB 667 "Facility Penalty & Remedy/Electron. Supervise" was next bill to be heard. Senator Hise explained the bill. After questions had been appropriately answered, Senator Bingham moved for a Favorable Report to the Committee Substitute, Unfavorable to original bill; motion carried.

Senator Pate then asked Senator Tucker to explain HB 747, "Youth Access to Kratom/Study Abuse OTC." After questions had been asked and answered, Senators McKissick and J. Davis moved for a Favorable Report as to the PCS, Unfavorable as to the original bill.

The last bill brought before the Committee was for discussion only - HB 161 "Repeal Certificate of Need Law." This was explained in detail by Senator Hise, with a question and answer time. Afterwards, the floor was opened for comment by the audience. The following individuals spoke relative to the bill: Dr. Charles Ford of Boone ENT, Dr. Richard Bruch of Triangle Orthopedic in Durham, Kathryn Restrepo of John Locke Foundation, Joseph Kyzer of Americans for Prosperity, Cody Hand of the Hospital Association, Carol Myer of the Carolinas Center for Hospice and End of Life Care, Jim Harrell of the NC Society of Anesthesiologists, and Marc Hewitt of Smith, Moore and Leatherwood.

The meeting adjourned at 12:15 pm.

Louis M Pate J.
Senator Louis Pate, Chair
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Friday, June 10, 2016 03:59 PM
To: Rep. Bobbie Richardson; Rep. Mike Hager; Rep. Josh Dobson; Rep. Nelson Dollar; Rep. Jonathan Jordan; Rep. Rena Turner; Rep. Beverly Earle; Rep. Chris Malone; Rep. Charles Jeter; Rep. Bert Jones; Sen. Tom McInnis
Cc: Anna Meadows (Rep. Bobbie Richardson); Baxter Knight (Rep. Mike Hager); Julie Ryan (Rep. Josh Dobson); Candace Slate (Rep. Nelson Dollar); Emma Benson (Rep. Jonathan Jordan); Barbara Gaiser (Rep. Rena Turner); Ann Raeford (Rep. Beverly Earle); Savannah Tedesco (Rep. Chris Malone); Brittany Eller (Rep. Charles Jeter); Brenda Olls (Rep. Bert Jones); Libby Spain (Sen. Tom McInnis)
Subject: <NCGA> Senate Health Care Committee Meeting Notice for Tuesday, June 14, 2016 at 11:00 AM
Attachments: Add Meeting to Calendar_LINC_.ics

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
Tuesday	June 14, 2016	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 161	Adopt State Cat. PCS will be offered that contains CON language.	Representative B. Richardson Representative Glazier
HB 667	StudyAthletic Trainer/Health Coverage Option.	Representative Hager Representative Dobson
HB 747	Electronic Supervision Waiver.	Representative Dollar Representative R. Turner Representative Dobson Representative Jordan
HB 1014	NC Pre-K Conforming Change/Taylor's Law.	Representative Dobson Representative Jeter Representative Malone

HB 1145	Disapprove Dental Examiners Rule.	Representative Earle Representative Jones
SB 830	Add Kratom to Controlled Substance List.	Senator McInnis

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

AGENDA

SENATE HEALTH CARE MEETING

June 14, 2016

11:00 AM

CALL MEETING TO ORDER

RECOGNIZE SERGEANTS-AT-ARMS

RECOGNIZE PAGES

BILLS TO BE CONSIDERED		SPONSOR
HB 161	Adopt State Cat (PCS will be offered that Contains CON language)	Rep. R. Richardson Rep. Glazier Rep. Glazier
HB 667	Study/Athletic Trainer/Health Coverage Option	Rep. Hager Rep. Dobson
HB 747	Electronic Supervision Waiver	Rep. Dollar Rep. R. Turner Rep. Dobson Rep. Jordan
HB 1014	NC Pre-K Conforming Change/Taylor Law	Rep. Dobson Rep. Jeter Rep. Malone Rep. Earle
HB 1145	Disapprove Dental Examiners Rule	Rep. Jones

ADJOURN

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, June 14, 2016

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

FAVORABLE

HB **1014 (CS#1)** NC Pre-K Conforming Change/Taylor's Law.

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

HB **1145 (CS#1)** Disapprove Dental Examiners Rule.

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

TOTAL REPORTED: 2

Senator Ralph Hise will handle HB 1014
Senator Jim Davis will handle HB 1145

CMR721-V-1

HOUSE BILL 1014:
NC Pre-K Conforming Change/Taylor's Law.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 14, 2016
Introduced by:	Reps. Dobson, Jeter, Malone, Earle	**Prepared by:**	Jennifer Mundt
Analysis of:	Second Edition		Committee Staff

SUMMARY: House Bill 1014 would make technical and conforming changes to replace references to "More at Four" with "NC Pre-K" in the General Statutes and rename Part 6 of Article 1B of Chapter 130A of the General Statutes to "Taylor's Law Establishing the Advisory Council on Rare Diseases."

[As introduced, this bill was identical to S799, as introduced by Sens. Pate, Robinson, which is currently in Senate Education/Higher Education.]

BILL ANALYSIS:

Sections 1 and 2 of the bill make technical and conforming changes to replace the obsolete reference to "More at Four" with "NC Pre-K" in two sections of the General Statutes.

Section 3 of the bill renames the Advisory Council on Rare Diseases, as established by S.L. 2015-199, "Taylor's Law Establishing the Advisory Council on Rare Diseases."

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

BACKGROUND: The Advisory Council on Rare Diseases was established in 2015 within the School of Medicine of the University of North Carolina at Chapel Hill to provide advice to the Governor, the Secretary of Health and Human Services, and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases[1].

Taylor King is a 17-year old resident of Charlotte who was diagnosed with Batten Disease, an extremely rare neurodegenerative disorder, when she was 7. Batten Disease causes the buildup of fatty substances called lipopigments in the body's tissues. This buildup leads to the death of neurons in the retina, brain, and central nervous system. Batten Disease is always fatal and there is no known treatment or cure. Taylor's Tale is a volunteer organization dedicated to the fight against Batten Disease and other rare diseases.

Jason Moran-Bates, counsel to the Senate Health Care Committee, contributed to this summary.

[1] Under 21 U.S.C. § 360bb "rare disease or condition" is defined to mean any disease or condition which (i) affects less than 200,000 persons in the United States, or (ii) affects more than 200,000 in the United States and for which there is no reasonable expectation that the cost of developing and making available in the United States a drug for such disease or condition will be recovered from sales in the United States of such drug.

Karen Cochrane-Brown
Director

H1014-SMTA-78 E2 -V-1

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 2

HOUSE BILL 1014*
Committee Substitute Favorable 5/11/16

Short Title: NC Pre-K Conforming Change/Taylor's Law. (Public)

Sponsors:

Referred to:

May 2, 2016

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES BY REMOVING OBSOLETE REFERENCES TO THE MORE AT FOUR PROGRAM IN THE GENERAL STATUTES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES, AND TO RENAME PART 6 OF ARTICLE 1B OF CHAPTER 130A OF THE GENERAL STATUTES TO TAYLOR'S LAW ESTABLISHING THE ADVISORY COUNCIL ON RARE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 115C-242 reads as rewritten:

"**§ 115C-242. Use and operation of school buses.**

Public school buses may be used for the following purposes only, and it shall be the duty of the superintendent of the school of each local school administrative unit to supervise the use of all school buses operated by such local school administrative unit so as to assure and require compliance with this section:

(1) A school bus may be used for the transportation of pupils enrolled in and employees in the operation of the school to which such bus is assigned by the superintendent of the local school administrative unit. Except as otherwise herein provided, such transportation shall be limited to transportation to and from such school for the regularly organized school day, and from and to the points designated by the principal of the school to which such bus is assigned, for the receiving and discharging of passengers. No pupil or employee shall be so transported upon any bus other than the bus to which such pupil or employee has been assigned pursuant to the provisions of this Article: Provided, that children enrolled in a Headstart program or any ~~More at Four~~ NC Pre-K program may be transported on public school buses, and any additional costs associated with such contractual arrangements shall be incurred by the benefitting Head Start or ~~More at Four~~ NC Pre-K program: Provided further, that children with disabilities may be transported to and from the nearest appropriate private school having a special education program approved by the State Board of Education if the children to be transported are or have been placed in that program by a local school administrative unit as a result of the State or the unit's duty to provide such children with a free appropriate public education.

...."

SECTION 2. G.S. 143B-168.12(a)(1)n. reads as rewritten:

"**§ 143B-168.12. North Carolina Partnership for Children, Inc.; conditions.**

(a) In order to receive State funds, the following conditions shall be met:

(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 26 members:

...

n. The Director of the ~~More at Four Pre-Kindergarten~~ NC Pre-K Program, or the Director's designee."

SECTION 3. Part 6 of Article 1B of Chapter 130A of the General Statutes reads as rewritten:

"Part 6. Taylor's Law Establishing the Advisory Council on Rare Diseases.

"**§ 130A-33.65. Advisory Council on Rare Diseases; membership; terms; compensation; meetings; quorum.**

(a) There is established the Advisory Council on Rare Diseases within the School of Medicine of the University of North Carolina at Chapel Hill to advise the Governor, the Secretary, and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases. This Part shall be known as Taylor's Law Establishing the Advisory Council on Rare Diseases. For purposes of this Part, "rare disease" has the same meaning as provided in 21 U.S.C. § 360bb.

...."

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

HOUSE BILL 1145:
Disapprove Dental Examiners Rule.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 13, 2016
Introduced by:	Rep. Jones	**Prepared by:**	Theresa Matula
Analysis of:	Second Edition		Committee Staff

SUMMARY: ***HB 1145 disapproves 21 NCAC 16Q .0101 General Anesthesia and Sedation Definitions, addresses issues pertaining to rules that should continue to be delayed; rules that could become effective although a delay was previously requested; and rules that became effective April 1, 2016, but the NC Board of Dental Examiners is directed not to enforce.***

CURRENT LAW: Under the Administrative Procedure Act (APA), contained in Chapter 150B, an agency adopting administrative rules must give the public notice of the proposed rules and an opportunity to comment. The agency may then adopt the rule, but the rules must be reviewed by the Rules Review Commission (Commission) before they can go into effect. If the rules are approved, they become effective on the first day of the month following review, unless the Commission receives written objections from 10 or more persons.

G.S. 150B-21.3(b1) Delayed Effective Dates- provides that if the Rules Review Commission received written objections to the rule, the rule becomes effective on the earlier of the thirty-first legislative day or the day of adjournment of the next regular session of the General Assembly that begins at least 25 days after the date the Commission approved the rule, unless a different effective date applies under this section.

If a bill that specifically disapproves the rule is introduced in either house of the General Assembly before the thirty-first legislative day of that session, the rule becomes effective on the earlier of either the day an unfavorable final action is taken on the bill or the day that session of the General Assembly adjourns without ratifying a bill that specifically disapproves the rule. If the agency adopting the rule specifies a later effective date than the date that would otherwise apply under this subsection, the later date applies. A permanent rule that is not approved by the Commission or that is specifically disapproved by a bill enacted into law before it becomes effective does not become effective.

G.S. 150B-21.3(b2) Objection – provides that if the Rules Review Commission receives written objections from 10 or more persons, no later than 5:00 P.M. of the day following the day the Commission approves the rule, clearly requesting review by the legislature in accordance with instructions posted on the agency's Web site and the Commission approves the rule, the rule will become effective as provided in subsection (b1) of this section. The Commission must notify the agency that the rule is subject to legislative disapproval on the day following the day it receives 10 or more written objections. When the requirements of this subsection have been met and a rule is subject to legislative disapproval, the agency may adopt the rule as a temporary rule if the rule would have met the criteria listed in G.S. 150B-21.1(a) at the time the notice of text for the permanent rule was published in the North Carolina Register.

If the Commission receives objections from 10 or more persons clearly requesting review by the legislature, and the rule objected to is one of a group of related rules adopted by the agency at the same

Karen Cochrane-Brown
Director

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time, the agency that adopted the rule may cause any of the other rules in the group to become effective as provided in subsection (b1) of this section by submitting a written statement to that effect to the Commission before the other rules become effective.

BILL ANALYSIS:

Section 1 of the HB 1145 disapproves 21 NCAC 16Q .0101 (General Anesthesia and Sedation Definitions). This rule was adopted by the North Carolina Board of Dental Examiners on December 12, 2015, and approved by the Rules Review Commission on March 17, 2016. Pursuant to G.S. 150B-21.3(b1), Section 1 of the bill disapproves 21 NCAC 16Q .0101 (General Anesthesia and Sedation Definitions). Because this bill has been introduced the rule is stayed until the end of Session, if no further action is taken, the rule will become effective. If HB 1145 is enacted, the rule is disapproved and will not become effective.

Sections 2, 3, and 4 are needed to address issues pertaining to rules that should continue to be delayed, rules that could become effective although a delay was previously requested, and rules that became effective April 1, 2016, but the NC Board of Dental Examiners is directed not to enforce.

Section 2 pertains to rules that were listed in written statement from the NC Board of Dental Examiners to the Rules Review Commission on March 31, 2016, submitted pursuant to G.S. 150B-21.3(b2). The written statement requested a delay of an additional group of rules because they were related to the rule described in Section 1. The rules included in this section are those rules listed in the written statement minus the rules covered by Section 3 of the bill. The rules covered by this section of the bill are disapproved to the same extent as the rule listed section 1 of the bill, meaning that the rules referenced above are stayed until the end of Session. If no further action is taken, the rule will become effective. If HB 1145 is enacted, the rules are disapproved and will not become effective.

Section 3 lists seven rules that were included in the written statement from the NC Board of Dental Examiners to the Rules Review Commission on March 31, 2016. This section of the bill provides that those seven rules are effective April 1, 2016.

Section 4 lists three rules that became effective April 1, 2016, but instructs the NC Board of Dental Examiners to continue to enforce these rules as they existed prior to the amendments that became effective on April 1, 2016.

EFFECTIVE DATE: House Bill 1145 would become effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

S 1

SENATE BILL 830

Short Title:	Add Kratom to Controlled Substance List.	(Public)
Sponsors:	Senators McInnis (Primary Sponsor); and Krawiec.	
Referred to:	Health Care	

May 11, 2016

A BILL TO BE ENTITLED

AN ACT TO ADD MITRAGYNINE AND 7-HYDROXYMITRAGYNINE, ALSO KNOWN AS KRATOM, TO THE LIST OF CONTROLLED SUBSTANCES AND TO APPROPRIATE FUNDS FOR THE STATE BUREAU OF INVESTIGATION TO ASSIST WITH OPERATING COSTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-89(2) reads as rewritten:

"**§ 90-89. Schedule I controlled substances.**

This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a high potential for abuse, no currently accepted medical use in the United States, or a lack of accepted safety for use in treatment under medical supervision. The following controlled substances are included in this schedule:

...

(2) Any of the following opium derivatives, including their salts, isomers, and salts of isomers, unless specifically excepted, or listed in another schedule, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

a. Acetorphine.
b. Acetyldihydrocodeine.
c. Benzylmorphine.
d. Codeine methylbromide.
e. Codeine-N-Oxide.
f. Cyprenorphine.
g. Desomorphine.
h. Dihydromorphine.
i. Etorphine (except hydrochloride salt).
j. Heroin.
k. Hydromorphinol.
l. Methyldesorphine.
m. Methyldihydromorphine.
n. Morphine methylbromide.
o. Morphine methylsulfonate.
p. Morphine-N-Oxide.
q. Myrophine.

r. Nicocodeine.
s. Nicomorphine.
t. Normorphine.
u. Pholcodine.
v. Thebacon.
w. Drotebanol.
x. Mitragynine.
y. 7-hydroxymitragynine."

SECTION 2. There is appropriated from the General Fund to the Department of Public Safety the sum of twenty-five thousand dollars ($25,000) for the 2016-2017 fiscal year to be allocated to the State Bureau of Investigation to assist with operating costs.

SECTION 3. Section 1 of this act becomes effective December 1, 2016, and applies to offenses committed on or after that date. The remainder of this act becomes effective July 1, 2016.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Tuesday, June 14, 2016

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

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

HB **667** **(CS#1)** StudyAthletic Trainer/Health Coverage Option.

Draft Number:	H667-PCS10549-SH-74
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Tommy Tucker will handle HB 667

HOUSE BILL 667:
Facility Penalty & Remedy/Electron. Supervise.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 13, 2016
Introduced by:	Reps. Hager, Dobson	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	PCS to Second Edition H667-CSSH-74		

SUMMARY: ***The Proposed Committee Substitute (PCS) to H667 would amend penalties and remedies for facilities that provide services to the mentally ill, developmentally disabled, and substance abusers and for adult care home facilities; defines the term "substantial risk"; allows flexibility in assessing an administrative penalty when the facility has provided training and has corrected the violation and remains in compliance; eliminates the penalty review committee for adult care homes; and repeals the June 30, 2016 sunset on the DHHS pilot program regarding electronic supervision devices.***

CURRENT LAW: Within **Chapter 122C, Article 2** deals with the licensure of facilities for the mentally ill, the developmentally disabled, and substance abusers, and Article 3 addresses the rights of patients in such facilities.

Subsection (a) of G.S. 122C-24.1 classifies types of violations of those statutes or other applicable State and federal laws, and sets forth procedures to be followed and penalties to be assessed in the event of such a violation. Currently, the list of types of violations includes a "past corrected Type A1 or A2 violation," for violations that existed at one time, but have been corrected and were either (i) not previously identified by the Department of Health and Human Services (DHHS), or (ii) was discovered by the facility and was self-reported. Such cases are counted as a violation, but DHHS has discretion as to whether to impose a penalty.

Subsection (c) of G.S. 122C-24.1 sets forth factors for the Department of Health and Human Services to consider in determining the amount of the penalty to be assessed for a violation, including instances of where "substantial risk" exists that serious physical harm, abuse, neglect, exploitation, or client death will occur. The term "substantial risk" is not currently defined in the statute.

Subsection (i) of G.S. 122C-24.1 allows the Secretary of DHHS to order a facility to provide staff training in lieu of assessing some or all of an administrative penalty imposed for a violation.

Chapter 131D deals with inspection and licensing of adult care homes. G.S. 131D-34 largely mirrors the penalty structures and procedures of the laws on mental health facilities, including the provisions detailed above. Additionally, for adult care homes, there is currently a penalty review committee within DHHS which reviews administrative penalties assessed pursuant to G.S. 131D-34.

S.L. 2015-264 (Technical Corrections), Section 91.4(a) continued and expanded the pilot program established by the Division of Health Service Regulation, DHHS, to study the use of electronic supervision devices as an alternative means of supervision during sleep hours at facilities for children and adolescents who have a primary diagnosis of mental illness and/or emotional disturbance. To facilitate the pilot program, 10A NCAC 27G.1704, which establishes the minimum staffing requirements for residential treatment facilities for children and adolescents, is waived. However, the

Division of Health Service Regulation is allowed to rescind the waiver if, at the time of the facility's license renewal, there are outstanding deficiencies that have remained uncorrected upon the follow-up surveys that are related to electronic supervision. **S.L. 2015-264, Section 91.4(b)** provides that the authorization for this pilot program is set to expire on June 30, 2016.

BILL ANALYSIS: Sections 1 & 2: The PCS would make the following changes to G.S. 122C-24.1 and G.S. 131D-34:

- Remove "past corrected Type A1 or Type A2 violation" from the list of type of violations and specify that a Type A1, Type A2, or Type B Violation is not considered a violation as long as all of the following criteria are met:
    - The violation was discovered by the facility.
    - DHHS determines that the violation was abated immediately.
    - The violation was corrected prior to inspection by DHHS.
    - DHHS determines that reasonable preventative measures were in place prior to the violation.
    - DHHS determines that subsequent to the violation, the facility implemented corrective measures to achieve and maintain compliance.
- Defines the term "substantial risk" as "the risk of an outcome that is substantially certain to materialize if immediate action is not taken."
- In lieu of assessing all or some of an administrative penalty, the Secretary of DHHS may order a facility to provide staff training, or consider the approval of training already completed, and the Secretary may also take into consideration whether the facility has corrected the violation and continues to remain in compliance with the regulation.

The PCS would also make the following two changes to Chapter 131D which will align the procedures for adult care homes more closely with those facilities licensed under Chapter 122C:

- Eliminate the penalty review committee for adult care homes.
- Change the date on which a penalty commences from the date on which a violation is identified to the date of the letter of notification of the penalty amount.

Section 3: The PCS would remove the June 30, 2016 sunset date on the pilot program authorized by Sections 91.4(a) and (b) of S.L. 2015-264.

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

Theresa Matula, Committee Staff, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

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HOUSE BILL 667
Committee Substitute Favorable 4/22/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H667-CSSH-74 [v.4]
06/13/2016 06:19:25 PM

Short Title: Facility Penalty & Remedy/Electron. Supervise. (Public)

Sponsors:

Referred to:

April 14, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND PENALTIES AND REMEDIES FOR FACILITIES LICENSED TO CARE FOR THE MENTALLY ILL, DEVELOPMENTALLY DISABLED, OR SUBSTANCE ABUSERS AND FOR ADULT CARE HOME FACILITIES; AND TO REMOVE THE SUNSET FOR THE PILOT PROGRAM TO STUDY THE USE OF ELECTRONIC SUPERVISION DEVICES IN CERTAIN FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-24.1 reads as rewritten:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violation Classification and Penalties. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations for violations shall be classified and penalties assessed according to the nature of the violation as follows:

(1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect clients from further risk or additional harm.

b. Within 15 working days of the investigation, send a report of the findings to the facility.

c. Require a plan of correction to be submitted to the Department, based on a written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A1 Violation in facilities or programs that serve six or fewer persons. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities or programs that serve seven or more

persons. Where a facility has failed to correct a Type A1 Violation, the Department shall access the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction. The Department or its authorized representative shall determine whether the violation has been corrected.

(1a) "Type A2 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A2 Violation and the specific findings.

b. Require a written plan of protection regarding how the facility will immediately abate the Type A2 Violation in order to protect clients or residents from further risk or additional harm.

c. Within 15 working days of the investigation, send a report of the findings to the facility.

d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The violation or violations shall be corrected within the time specified for correction by the Department or its authorized representative. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Where a facility has failed to correct a Type A2 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

~~(1b) "Past-Corrected Type A1 or Type A2 Violation" means either (i) the violation was not previously identified by the Department or its authorized representative or (ii) the violation was discovered by the facility and was self-reported, but in either case the violation has been corrected. In determining whether a penalty should be assessed under this section, the Department shall consider the following factors:~~

~~a. Preventative measures in place prior to the violation.~~

~~b. Whether the violation or violations were abated immediately.~~

~~c. Whether the facility implemented corrective measures to achieve and maintain compliance.~~

~~d. Whether the facility's system to ensure compliance is maintained and continues to be implemented.~~

~~e. Whether the regulatory area remains in compliance.~~

(1c) As used in this section, "substantial risk" shall mean the risk of an outcome that is substantially certain to materialize if immediate action is not taken.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which is detrimental to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm,

abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type B Violation and the specific findings.

b. Require a written plan of protection regarding how the facility will immediately abate the Type B Violation in order to protect clients or residents from further risk or additional harm.

c. Within 15 working days of the investigation, send a report of the findings to the facility.

d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars ($400.00) for each day that the violation continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(2a) A Type A1, Type A2, or Type B Violation as defined above shall not include a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility if all of the following criteria are met:

a. The violation was discovered by the facility.

b. The Department determines that the violation was abated immediately.

c. The violation was corrected prior to inspection by the Department.

d. The Department determines that reasonable preventative measures were in place prior to the violation.

e. The Department determines that subsequent to the violation, the facility implemented corrective measures to achieve and maintain compliance.

(3) Repeat Violations. – The Department shall impose a civil penalty which is treble the amount assessed under this subsection when a facility under the same management or ownership has received a citation during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred, and the current violation is for the same specific provision of a statute or regulation for which it received a violation during the previous 12 months.

(b) Repealed by Session Laws 2011-249, s. 1, effective June 23, 2011.

(c) Factors to Be Considered in Determining Amount of Initial Penalty. – In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) There is substantial risk that serious physical harm, abuse, neglect, or exploitation will occur, and this has not been corrected within the time specified by the Department or its authorized representative;

(2) Serious physical harm, abuse, neglect, or exploitation, without substantial risk for client death, did occur;

(3) Serious physical harm, abuse, neglect, or exploitation, with substantial risk for client death, did occur;
(3a) A client died;
(3b) A client died and there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation;
(3c) A client died and there is substantial risk for further client death;
(4) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and other applicable State and federal laws and regulations;
(5) Efforts by the licensee to correct violations;
(6) The number and type of previous violations committed by the licensee within the past 36 months; and
(7) Repealed by Session Laws 2011-249, s. 1, effective June 23, 2011.
(8) The number of clients or patients put at risk by the violation.

(d) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:
(1) The licensee involved;
(2) The clients or patients affected; and
(3) The family members or guardians of the clients or patients affected.

(e) The Department shall impose a civil penalty of fifty dollars ($50.00) per day on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(f) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:
(1) The reasonableness of the amount of any civil penalty assessed, and
(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(g) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the date of the letter of notification of the penalty amount.

(h) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:
(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or
(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-37.

(i) In lieu of assessing all or some of the administrative penalty, the Secretary may order a facility to provide staff ~~training~~training, or consider the approval of training completed by the facility after the violation, ~~if the training is:~~if all of the following criteria are met:
(1) The training is determined by the Department to be specific to the violation. ~~Specific to the violation;~~
(2) The training is approved ~~Approved~~ by the Department. ~~Department of Health and Human Services; and~~
(3) The training is taught ~~Taught~~ by someone approved by the Department.
(4) The facility has corrected the violation and continues to remain in compliance with the regulation.

(j) The clear proceeds of civil penalties provided for in this section shall be remitted to the State Treasurer for deposit in accordance with State law.

(k) In considering renewal of a license, the Department shall not renew a license if outstanding fines and penalties imposed by the Department against the facility or program have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration for nonrenewal under this subsection."

SECTION 2. G.S. 131D-34 reads as rewritten:

"**§ 131D-34. Penalties; remedies.**

(a) Violation Classification and Penalties. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility which is found to be in violation of requirements of G.S. 131D-21 or applicable State and federal laws and regulations. Citations for violations shall be classified and penalties assessed according to the nature of the violation as follows:

(1) "Type A1 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, abuse, neglect, or exploitation. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.

a1. Require a written plan of protection regarding how the facility will immediately abate the Type A1 Violation in order to protect residents from further risk or additional harm.

b. Within 15 working days of the investigation, send a report of the findings to the facility.

c. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A1 Violation in facilities licensed for six or fewer beds. The Department shall impose a civil penalty in an amount not less than one thousand dollars ($1,000) nor more than twenty thousand dollars ($20,000) for each Type A1 Violation in facilities licensed for seven or more beds. Where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the violation continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

(1a) "Type A2 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type A2 Violation and the specific findings.

b. Require a written plan of protection regarding how the facility will immediately abate the Type A2 Violation in order to protect clients or residents from further risk or additional harm.

c. Within 15 working days of the investigation, send a report of the findings to the facility.
d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

The violation or violations shall be corrected within the time specified for correction by the Department or its authorized representative. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Where a facility has failed to correct a Type A2 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars ($1,000) for each day that the deficiency continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

~~(1b) "Past Corrected Type A1 or Type A2 Violation" means either (i) the violation was not previously identified by the Department or its authorized representative or (ii) the violation was discovered by the facility and was self-reported, but in either case the violation has been corrected. In determining whether a penalty should be assessed under this section, the Department shall consider the following factors:~~

~~a. Preventive systems in place prior to the violation.~~
~~b. Whether the violation or violations were abated immediately.~~
~~c. Whether the facility implemented corrective measures to achieve maintain compliance.~~
~~d. Whether the facility's system to ensure compliance is maintained and continues to be implemented.~~
~~e. Whether the regulatory area remains in compliance.~~

(1c) As used in this section, "substantial risk" shall mean the risk of an outcome that is substantially certain to materialize if immediate action is not taken.

(2) "Type B Violation" means a violation by a facility of the regulations, standards and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility which is detrimental to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. The person making the findings shall do the following:

a. Orally and immediately inform the facility of the Type B Violation and the specific findings.
b. Require a written plan of protection regarding how the facility will immediately abate the Type B Violation in order to protect residents from further risk or additional harm.
c. Within 15 working days of the investigation, send a report of the findings to the facility.
d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance.

Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars ($400.00) for each day that the violation continues beyond the date specified for correction without just reason for such failure. The

Department or its authorized representative shall ensure that the violation has been corrected.

(2a) A Type A1, Type A2, or Type B Violation as defined above shall not include a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131D-21 or applicable State or federal laws and regulations governing the licensure or certification of a facility if all of the following criteria are met:

a. The violation was discovered by the facility.

b. The Department determines that the violation was abated immediately.

c. The violation was corrected prior to inspection by the Department.

d. The Department determines that reasonable preventative measures were in place prior to the violation.

e. The Department determines that subsequent to the violation, the facility implemented corrective measures to achieve and maintain compliance.

(3) Repeat Violations. – The Department shall impose a civil penalty which is treble the amount assessed under subsection (a) of this section when a facility under the same management or ownership has received a citation during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred, and the current violation is for the same specific provision of a statute or regulation for which it received a violation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a court-appointed temporary manager pursuant to Article 4 of this Chapter.

(b) Repealed by Session Laws 2011-249, s. 2, effective June 23, 2011.

(c) Factors to Be Considered in Determining Amount of Initial Penalty. – In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) There is substantial risk that serious physical harm, abuse, neglect, or exploitation will occur;

(1a) Serious physical harm, abuse, neglect, or exploitation, without substantial risk for resident death, did occur;

(1b) Serious physical harm, abuse, neglect, or exploitation, with substantial risk for resident death, did occur;

(1c) A resident died;

(1d) A resident died and there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation;

(1e) A resident died and there is substantial risk for further resident death;

(2) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131D-40 and other applicable State and federal laws and regulations;

(2a) Efforts by the licensee to correct violations;

(3) The number and type of previous violations committed by the licensee within the past 36 months; and

(4) Repealed by Session Laws 2011-249, s. 2, effective June 23, 2011;

(5) The number of residents put at risk by the violation.

(c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:

~~(1) The penalty review committee;~~

(2) The local department of social services who is responsible for oversight of the facility involved;
(3) The licensee involved;
(4) The residents affected; and
(5) The family member who serves as a responsible party or those who have legal authority on behalf of the affected resident.

(c2) Local county departments of social services and Division of Health Service Regulation personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation.

(d) The Department shall impose a civil penalty of fifty dollars ($50.00) per day on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(d1) The Department shall impose a civil penalty on any applicant for licensure who provides false information or omits information on the portion of the licensure application requesting information on owners, administrators, principals, or affiliates of the facility. The amount of the penalty shall be as is prescribed for a Type A1 Violation.

(e) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:
(1) The reasonableness of the amount of any civil penalty assessed, and
(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the administrative law judge may order that the penalty be adjusted accordingly.

(f) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the date ~~the violation was identified.~~of the letter of notification of the penalty amount.

(g) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:
(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or
(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(g1) In lieu of assessing all or some of the administrative penalty, the Secretary may order a facility to provide staff ~~training if the training is:~~training, or consider the approval of training completed by the facility after the violation, if all of the following criteria are met:
(1) ~~Specific to the violation;~~The training is determined by the Department to be specific to the violation.
(2) The training is approved ~~Approved~~ by the ~~Department of Health and Human Services; and~~Department.
(3) The training is taught ~~Taught~~ by someone approved by the Department.
(4) The facility has corrected the violation and continues to remain in compliance with the regulation.

~~(h) The Secretary shall establish a penalty review committee within the Department, which shall meet as often as needed, but no less frequently than once each quarter of the year, to review administrative penalties assessed pursuant to this section and pursuant to G.S. 131E-129 as follows:~~

~~(1) The Secretary shall administer the work of the Committee and provide public notice of its meetings via Web site, and provide direct notice to the following parties involved in the penalties the Committee will be reviewing:~~

~~a. The licensed provider, who upon receipt of the notice, shall post the notice of the scheduled Penalty Review Committee meeting in a conspicuous place available to residents, family members, and the public;~~

~~b. The local department of social services that is responsible for oversight of the facility involved;~~

~~c. The residents affected; and~~

~~d. Those individuals lawfully designated by the affected resident to make health care decisions for the resident.~~

~~(2) The Secretary shall ensure that the Nursing Home/Adult Care Home Penalty Review Committee established by this subsection is comprised of nine members. At least one member shall be appointed from each of the following categories:~~

~~a. A licensed pharmacist;~~

~~b. A registered nurse experienced in long-term care;~~

~~c. A representative of a nursing home;~~

~~d. A representative of an adult care home; and~~

~~e. Two public members. One shall be a "near" relative of a nursing home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. One shall be a "near" relative of a rest home patient, chosen from a list prepared by the Office of State Long Term Care Ombudsman, Division of Aging, Department of Health and Human Services. For purposes of this subdivision, a "near" relative is a spouse, sibling, parent, child, grandparent, or grandchild.~~

~~(3) Neither the pharmacist, nurse, nor public members appointed under this subsection nor any member of their immediate families shall be employed by or own any interest in a nursing home or adult care home.~~

~~(4) Repealed by Session Laws 2005-276, s. 10.40A(l), effective July 1, 2005.~~

~~(4a) Repealed by Session Laws 2007-544, s. 1, effective October 1, 2007.~~

~~(4b) Prior to serving on the Committee, each member shall complete a training program provided by the Department of Health and Human Services that covers standards of care and applicable State and federal laws and regulations governing facilities licensed under Chapter 131D and Chapter 131E of the General Statutes.~~

~~(5) Each member of the Committee shall serve a term of two years. The initial terms of the members shall commence on August 3, 1989. The Secretary shall fill all vacancies. Unexcused absences from three consecutive meetings constitute resignation from the Committee.~~

~~(6) The Committee shall be cochaired by:~~

~~a. One member of the Department outside of the Division of Health Service Regulation; and~~

~~b. One member who is not affiliated with the Department.~~

(i) The clear proceeds of civil penalties provided for in this section shall be remitted to the State Treasurer for deposit in accordance with State law."

SECTION 3. S.L. 2015-264, Section 91.4.(b) is repealed.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 2

HOUSE BILL 667
Committee Substitute Favorable 4/22/15

Short Title: StudyAthletic Trainer/Health Coverage Option. (Public)

Sponsors:

Referred to:

April 14, 2015

A BILL TO BE ENTITLED

AN ACT TO STUDY WHETHER TO ENSURE THAT PATIENTS HAVE THE OPTION OF SELECTING THEIR ATHLETIC TRAINER UNDER THEIR HEALTH BENEFIT PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission (LRC) shall study whether to ensure that North Carolina patients have a right to choose their athletic trainer under their health benefit plans. As part of its study, the LRC shall consider whether to add athletic trainers to G.S. 58-50-30.

SECTION 2. The LRC shall report its findings, together with any proposed legislation, to the 2016 Regular Session of the 2015 General Assembly upon its convening.

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

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Wednesday, June 15, 2016

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

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

HB **747** **(CS#1)** Electronic Supervision Waiver.

Draft Number:	H747-PCS10551-TY-18
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Tom McInnis will handle HB 747

HOUSE BILL 747:
Youth Access to Kratom/Study Abuse OTC Subs.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 10, 2016
Introduced by:		**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	PCS to Second Edition H747-CSTY-18		

SUMMARY: ***The Proposed Committee Substitute (PCS) to House Bill 747 would create a new section in Article 39 of Chapter 14 of the General Statutes (Protection of Minors) that would make it unlawful to sell or distribute kratom to minors under the age of 18, and for minors under the age of 18 to purchase or accept kratom products. The PCS would further direct the Legislative Research Commission to conduct a study on the public health impacts of kratom and nitrous oxide "whippets," including any legitimate medicinal use of kratom.***

CURRENT LAW: The distribution and possession of kratom is not currently regulated under North Carolina or federal law. Under the North Carolina Toxic Vapors Act (Article 5A of Chapter 90), it is unlawful to knowingly breath or inhale any substance for the purpose of inducing a condition of intoxication, or to sell or possess a substance for that purpose.

BILL ANALYSIS:

Section 1 of the PCS would regulate the sale and distribution of kratom products to persons under 18 years of age. Purchasing, receiving, or attempting to purchase or receive kratom products by a person under 18 years of age would be an infraction. Sale or distribution to, or aiding or abetting a person under 18 years of age in purchasing, acquiring, receiving, or attempting to purchase, receive, or acquire kratom products would be punished as a Class 2 misdemeanor, however the PCS would specifically allow deferred prosecution or conditional discharge provided a defendant has not previously been placed on probation for such a violation.

Section 2 of the PCS would direct the Legislative Research Commission to conduct a study on the impact to the public health of the use of kratom and of nitrous oxide "whippets." In conducting the study, the Commission would be required to seek the input from the Administrative Office of the Courts, the Office of the Chief Medical Examiner, and the Divisions of Public Health and Mental Health, Developmental Disabilities and Substance Abuse within the Department of Health and Human Services.

EFFECTIVE DATE: Section 1 would become effective December 1, 2016 and apply to offenses committed on or after that date. The remainder would be effective when it becomes law.

Karen Cochrane-Brown
Director

H747-SMTY-44 CSTY-18 -V-4

Legislative Analysis
Division
919-733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 747
Committee Substitute Favorable 4/27/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H747-CSTY-18 [v.4]
06/13/2016 05:22:45 PM

Short Title: Youth Access to Kratom/Study Abuse OTC Subs. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO REGULATE THE SALE OF MITRAGYNINE AND 7-HYDROXYMITRAGYNINE, ALSO KNOWN AS KRATOM, TO MINORS, AND TO STUDY THE ABUSE OF KRATOM AND NITROUS OXIDE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 39 of Chapter 14 of the General Statutes is amended by adding a new section after G.S. 14-313 to read:

"**§ 14-313.1. Youth access to kratom.**

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

(1) Distribute. – To sell, furnish, give, or provide any product containing kratom 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) Kratom product. – Any product containing any part of the plant Mitragyna speciosa, whether growing or not, and any compound, manufacture, salt, derivative, mixture, or preparation of that plant, including but not limited to mitragynine or 7-hydroxymitragynine.

(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 kratom products to any person under the age of 18 years, or if any person shall purchase kratom products on behalf of a 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 kratom products to an employee when required in the performance of the employee's duties.

A person engaged in the sale of kratom products 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. Retail distributors of kratom products 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. 20-37.7, a military identification card, or passport showing the purchaser's date of birth and bearing a physical description of the person named on the card.

(c) **Internet distribution of kratom products.** – A person engaged in the distribution of kratom 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 kratom products is 18 years of age or older.

(d) **Purchase by persons under the age of 18 years.** – If any person under the age of 18 purchases or accepts receipt, or attempts to purchase or accept receipt, of kratom products, 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 kratom product, the person shall be guilty of an infraction; provided, however, that it shall not be unlawful for an employee to purchase or accept receipt of kratom products when required in the performance of the employee's duties.

(e) **Sending or assisting a person less than 18 years of age to purchase or receive kratom products.** – If any person shall send a person less than 18 years of age any kratom product, 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 kratom products, 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 methodologically valid statistical study of the extent of success the State has achieved in reducing the availability of kratom products to persons under the age of 21.

(f) **Deferred Prosecution or Conditional Discharge.** – Notwithstanding G.S. 15A-1341(a1) or G.S. 15A-1341(a4), any person charged with a misdemeanor under this section shall be qualified for deferred prosecution or a conditional discharge pursuant to Article 82 of Chapter 15A of the General Statutes provided the defendant has not previously been placed on probation for a violation of this section and so states under oath."

SECTION 2. The Legislative Research Commission shall conduct a study on the impact on the public health of the use of kratom, including the existence of any legitimate medicinal use, if any, of kratom, and the impact on the public health of the use of nitrous oxide "whippets." During the course of the study, the Commission shall seek input from the Administrative Office of the Courts, the Office of the Chief Medical Examiner, and Divisions of Public Health and Mental Health, Developmental Disabilities, And Substance Abuse, within the Department of Health and Human Services. The Legislative Research Commission shall report its findings, together with any proposed legislation, to the 2017 Regular Session of the 2017 General Assembly upon its convening.

SECTION 3. Section 1 of this act becomes effective December 1, 2016, and applies to offenses committed on or after that date. The remainder of the act is effective when it becomes law.

HOUSE BILL 747
Committee Substitute Favorable 4/27/15

Short Title: Electronic Supervision Waiver. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO REMOVE THE SUNSET FOR THE PILOT PROGRAM TO STUDY THE USE OF ELECTRONIC SUPERVISION DEVICES IN CERTAIN FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. Notwithstanding any other provision of law, the pilot program established by the Department of Health and Human Services, Division of Health Service Regulation, to study the use of electronic supervision devices as an alternative means of supervision during sleep hours at facilities for children and adolescents who have a primary diagnosis of mental illness and/or emotional disturbance shall remain in effect and shall extend to facilities that are authorized to provide services in accordance with Section .1700 of the North Carolina Administrative Code, Residential Treatment Staff Secure for Children or Adolescents, currently owned or operated with the facility currently authorized to waive the requirement set forth in 10A NCAC 27G .1704(c) or any related or subsequent rule or regulation by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services setting minimum overnight staffing requirements. The waiver for these facilities shall remain in effect; however, the Division reserves the right to rescind the waiver if, at the time of the facility's license renewal, there are outstanding deficiencies that have remained uncorrected upon follow-up survey that are related to electronic supervision.

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

HOUSE BILL 161:
Repeal Certificate of Need Law.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 13, 2016
Introduced by:	Reps. B. Richardson, Glazier	**Prepared by:**	Jason Moran-Bates
Analysis of:	PCS to First Edition H161-CSRW-65		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute (PCS) to House Bill 161 would repeal North Carolina's Certificate of Need (CON) law, which is codified as Article 9 of Chapter 131E of the General Statutes. The PCS also makes technical and conforming changes by removing references to the CON law in other sections of the General Statutes.***

CURRENT LAW: Under current law, any person wanting to offer or develop a "new institutional health service" must first obtain a CON from the Department of Health and Human Services (DHHS). The term "new institutional health service" includes:

- Constructing or acquiring an interest in a new health service facility;
- Making a capital expenditure in excess of $2,000,000 to develop or expand a health service or health service facility;
- Changing the bed capacity of an existing facility;
- Offering any of the following services: dialysis, home health services, bone marrow transplants, burn intensive care, cardiac catheterization, neonatal intensive care, open-heart surgery, or solid organ transplants;
- Acquiring any of the following equipment: air ambulances, cardiac catheterization equipment, gamma knives, heart-lung bypass machines, linear accelerators, lithotriptors, MRI machines, PET scanners, or stimulators;
- Constructing or developing a hospice; converting a specialty ambulatory surgical program to a multispecialty ambulatory surgical program; and
- Constructing, expanding, or developing an operating room or gastrointestinal endoscopy room.

A person desiring a CON must submit an application and fee to the Division of Health Service Regulation of DHHS and furnish information upon which the Division can determine whether the application is consistent with the need determinations and policies contained in the current State Medical Facilities Plan and the criteria listed in G.S. 131E-183.

BILL ANALYSIS:

Section 1.(k) of the PCS would repeal Article 9 of Chapter 131E, *"Certificate of Need."*

Sections 1.(a) would delete from G.S. 6-19.1, *"Attorney's fees to parties appealing or defending against agency decision,"* a reference to attorney's fees for the administrative review portion of the case in contested cases arising under the certificate of need law.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

Section 1.(b) would provide that Section 1.(a) applies to contested cases arising on or after January 1, 2021.

Sections 1.(c) through 1.(j) would make technical and conforming changes by removing references to Article 9 of Chapter 131E in other sections of the General Statutes or by redefining terms that reference that Article.

EFFECTIVE DATE: This act becomes effective January 1, 2021.

BACKGROUND: Many Certificate of Need laws initially were put into effect across the nation as part of the federal "Health Planning Resources Development Act" of 1974. North Carolina's CON law was originally enacted in 1977 and has been amended several times since that time. The federal mandate was repealed in 1987, along with its federal funding. The General Assembly's Legislative Research Commission Committee on Care Provided by Rest Homes, Intermediate Care Facilities, and Skilled Nursing Homes; Necessity for Certificates of Need; and Continuing Care Issues undertook a review of the program in 1991, and again during the 2011-2012 biennium through the House Select Committee on the Certificate of Need Process and Related Hospital Issues. The Select Committee's website can be found at http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=146, and the interim and final reports are at
http://www.ncleg.net/documentsites/committees/HSCCONPRHI/04-19-12/HSCCON_final_report_4-23.pdf
and
http://www.ncleg.net/documentsites/committees/HSCCONPRHI/12-06-12/12-06-12_HSCCON_Final Report.pdf.

Jan Paul, staff attorney, substantially contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 161
PROPOSED SENATE COMMITTEE SUBSTITUTE H161-CSRW-65 [v.3]
06/13/2016 06:03:31 PM

Short Title: Repeal Certificate of Need Law. (Public)

Sponsors:

Referred to:

March 9, 2015

A BILL TO BE ENTITLED

AN ACT REPEALING NORTH CAROLINA'S CERTIFICATE OF NEED LAW.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 6-19.1(a) reads as rewritten:

"(a) In any civil action, other than an adjudication for the purpose of establishing or fixing a rate, or a disciplinary action by a licensing board, brought by the State or brought by a party who is contesting State action pursuant to G.S. 150B-43 or any other appropriate provisions of law, unless the prevailing party is the State, the court may, in its discretion, allow the prevailing party to recover reasonable attorney's fees, including attorney's fees applicable to the administrative review portion of the case, in contested cases arising under Article 3 of Chapter 150B, to be taxed as court costs against the appropriate agency if:

(1) The court finds that the agency acted without substantial justification in pressing its claim against the party; and

(2) The court finds that there are no special circumstances that would make the award of attorney's fees unjust. The party shall petition for the attorney's fees within 30 days following final disposition of the case. The petition shall be supported by an affidavit setting forth the basis for the request.

~~Nothing in this section shall be deemed to authorize the assessment of attorney's fees for the administrative review portion of the case in contested cases arising under Article 9 of Chapter 131E of the General Statutes.~~

Nothing in this section grants permission to bring an action against an agency otherwise immune from suit or gives a right to bring an action to a party who otherwise lacks standing to bring the action.

Any attorney's fees assessed against an agency under this section shall be charged against the operating expenses of the agency and shall not be reimbursed from any other source."

SECTION 1.(b) Subsection (a) of this section applies to contested cases arising on or after January 1, 2021.

SECTION 1.(c) G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care

facility as defined in ~~G.S. 131E-176(9b)~~this section or the laws of another state to operate as a health care facility; or a pharmacy.

...

(9a) "Health service facility" means a hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; diagnostic center; hospice office, hospice inpatient facility, and hospice residential care facility; and ambulatory surgical facility.

...."

SECTION 1.(d) G.S. 58-55-35(a) reads as rewritten:

"(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

...

(10) "Hospice" ~~shall be defined in accordance with the terms of G.S. 131E-176(13a).~~means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(11) "Intermediate care facility for the mentally retarded" ~~shall be defined in accordance with the terms of G.S. 131E-176(14a).~~means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with mental retardation, autism, cerebral palsy, epilepsy, or related conditions.

...."

SECTION 1.(e) G.S. 90-21.36(b) reads as rewritten:

"(b) Nothing in this Article shall exempt physicians or others from compliance with ~~State or~~ federal laws governing certificate of need, licensure, or other regulatory requirements."

SECTION 1.(f) G.S. 113A-12(3)e. reads as rewritten:

"e. A health care facility financed pursuant to Chapter 131A of the General ~~Statutes or receiving a certificate of need under Article 9 of Chapter 131E of the General~~ Statutes."

SECTION 1.(g) G.S. 122C-23.1(e) reads as rewritten:

"(e) As used in this section, "residential treatment facility" means a "residential facility" as defined in and licensed under this ~~Chapter, but not subject to Certificate of Need requirements under Article 9 of Chapter 131E of the General Statutes.~~Chapter."

SECTION 1.(h) G.S. 131E-13(a)(1) reads as rewritten:

"(1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed ~~by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable,~~ by review procedure designed to guarantee public

participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services."

SECTION 1.(i) G.S. 131E-136(4) reads as rewritten:

"(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent ~~basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.~~basis."

SECTION 1.(j) G.S. 148-19.1 reads as rewritten:

"**§ 148-19.1. Exemption from ~~licensure and certificate of need.~~licensure.**

~~(a)~~ Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Division of Adult Correction of the Department of Public Safety shall be exempt from licensure by the Department of Health and Human Services under Chapter 122C of the General Statutes. If an inpatient chemical dependency or substance abuse facility provides services both to inmates of the Division of Adult Correction of the Department of Public Safety and to members of the general public, the portion of the facility that serves inmates shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Division of Adult Correction of the Department of Public Safety may construct and operate a new chemical dependency or substance abuse facility for that purpose without first obtaining a certificate of need from the Department of Health and Human Services pursuant to Article 9 of Chapter 131E of the General Statutes. However, a new facility or addition developed for that purpose without a certificate of need shall not be licensed pursuant to Chapter 122C of the General Statutes and shall not admit anyone other than inmates unless the owner or operator first obtains a certificate of need.~~"

SECTION 1.(k) Article 9 of Chapter 131E of the General Statutes, G.S. 130A-45.02(i), 143B-1292, 150B-2(8a)k., and 150B-21.1(6) are repealed.

SECTION 1.(l) This act becomes effective January 1, 2021.

HOUSE BILL 161

Short Title:	Adopt State Cat.	(Public)
Sponsors:	Representatives Richardson and Glazier (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Wildlife Resources, if favorable, Rules, Calendar, and Operations of the House.	

March 9, 2015

A BILL TO BE ENTITLED

AN ACT ADOPTING THE BOBCAT AS THE OFFICIAL STATE CAT OF THE STATE OF NORTH CAROLINA.

Whereas, the bobcat is a member of the North American cat family and is found throughout North Carolina, especially in the wooded habitats of the coastal plain and mountains; and

Whereas, the bobcat is easily recognized by its short "bobbed" tail, round face with long hairs that resemble "sideburns," and pointed ears; and

Whereas, bobcats are somewhat larger than domestic cats, standing from 20 to almost 30 inches at the shoulder and weighing up to 40 pounds, with males being slightly larger than females; and

Whereas, bobcats are carnivores usually preying on rabbits and mice, but are also known to eat other animals, including deer, birds, raccoons, opossums, squirrels, and reptiles; and

Whereas, bobcats are active throughout the day, but are most active at dawn and dusk; and

Whereas, adopting the bobcat as the official State cat of North Carolina would help bring about awareness of this magnificent and beneficial animal; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 145 of the General Statutes is amended by adding the following new section to read:

"**§ 145-48. State cat.**

The bobcat is adopted as the official cat of the State of North Carolina."

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

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

Health Care

June 14, 2016

Room: 544

11:00 AM

Senate Sergeant at Arms:

Larry Hancock

Sham Patel

Becky Myrick

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 544

DATE: 6-14 **TIME:** 11 AM

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

Page Name	Hometown	Sponsoring Senator
1. Amy Clemmons	Raleigh	Alexander
2. Greear Webb	Raleigh	Alexander
3. Kellyanne Faulk	Sanford	Rabin
4. Hagan Disbrow	Southport	Rabon
5. Jordyn Scheitler	Belmont	Harrington
6. Seth Norwood	Greensboro	Berger
7. Owen Tierney III	Raleigh	Berger
8. Griffin Sullivan	Raleigh	Alexander
9. Will Pruthi	Durham	Foushee
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

June 14, 2016 – Room 544 – 11:00 AM

PLEASE SIGN IN BELOW

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Reed Caldwell	Southeastern Health
Elmon Robinson	NCRMA
Stephen Kouba	CCS
Ryan Blackledge	Com Health
Fred Bone	Bone Asso.
Kara Weishaar	SA
Cameron Nieters	KTS
Chris McClure	BOO
Amanda Donovan	TSS
Tabitha Bush	American Kratom Assoc
[illegible]	CGA
[illegible]	Fms [illegible]
[illegible]	MVA
Donna Sykes	NCHAS
Rob Lamaze	PhA
Cathy Meyers	The Carolinas Center for Hospice
[illegible] Killian	Nelson Mullins

Senate Committee on Health Care

June 14, 2016 – Room 544 – 11:00 AM

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John Rustin	NCFPC
[illegible]	
Daniel VanLiere	Vidant Health
Lisa Ward	NCDS
W H Potter Jr	NCDS & NCDTA
J.D. Watson	FCC / IRS / Clinton Volunteer
J McFarell	Bode Howell
Adam Sholar	NCHCFA
Laura Davis	LCSW for Kratom

Senate Committee on Health Care

June 14, 2016 – Room 544 – 11:00 AM

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NAME	FIRM OR AGENCY
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John McMillan	MF&S
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[illegible]	MP
Jan Carr	Hospice
Carol Mayo	Hospice
Elizabeth Dutton	Novant Health
TJ Bogbee	NP
Michael Hauser	THCG
Sarah McQuillan	SSGNC
Christine Craig	WakeMed
Lori Krou	Novant Health
Richard Branch	Triangle Orthopaedic Assoc. PA
LAURA PURYEAR	LOLLC
KELSEY BYERLY	LOLLC
Betsy McCorkle	SSGNC

Senate Committee on Health Care

June 14, 2016 – Room 544 – 11:00 AM

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Mary Cain	Noble Kava
Jackson Grotophorst	Noble Kava
Daniel Joy	Noble Kava
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Meghan Cook	NC DIT
Maeve Gordon	GSK
Mary Miller	ANGA

Senate Committee on Health Care

June 14, 2016 – Room 544 – 11:00 AM

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Vernon Jones	SJLLC
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Mary Cain	- Self. -
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Susan Ash	American Kratom Association
Elizabeth Gardner	NC Business Owner + Resident
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Senate Committee on Health Care

June 14, 2016 – Room 544 – 11:00 AM

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TRACY GOLVARD	~~FHP~~
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Eadie Rowell	Zebulon
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Patrick Sanderson	Noble Kava, Asheville
Kelsey Klingenmeyer	Noble Kava, Asheville
Sarah Bales	Brubaker & Associates
~~Hayden Bourgeois~~	~~FSP~~
Daniel Baum	TD Sherman Sanders
~~R. Braun Adams~~	~~KMA~~ The American Kratom Society
Nicole Deeny	AKA - Rooted Kava Lounge Willmington

Senate Committee on Health Care
Friday, June 24, 2016 at 11:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 11:30 AM on June 24, 2016, in Room 643 of the Legislative Office Building. Six members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing the pages—Austin Davis of Raleigh and Sean Thomas of Fayetteville, and the Sergeants-at-Arms— John Enloe and Giles Jeffreys.

Senator Hise noted that Senator Pate moved for consideration of the PCS for House Bill 424–Fostering Success; the motion passed. Senator Hise then recognized Senator Barringer to present the PCS. After a committee discussion of the PCS, Senator McKissick moved for a favorable report on the PCS. The motion passed and the bill was referred to Judiciary I.

Senator Hise then recognized Representative Avila to present House Bill 1033–ID Card Fee Waiver/Disability. Senator Randleman moved for a favorable report to the bill; the motion passed.

The committee then took up House Bill 842–Medicaid Waiver Protections/Military Families. Senator Tucker moved for consideration of the PCS for the bill. Representative Martin presented the PCS and Senator Pate moved for a favorable report on the PCS. The motion passed.

The meeting adjourned at 12:15 PM.

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Senate Committee on Health Care
Friday, June 24, 2016, 11:30 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 424	Fostering Success.	Representative Stevens Representative Glazier
HB 1033	ID Card Fee Waiver/Disability.	Representative Hardister Representative Lewis Representative Avila Representative Bryan
HB 842	Medicaid Waiver Protections/Military Families.	Representative G. Martin Representative Avila Representative Adcock

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Friday, June 24, 2016

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

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

HB **424** Fostering Success.

Draft Number:	H424-PCS10567-SH-78
Sequential Referral:	None
Recommended Referral:	Judiciary I
Long Title Amended:	Yes

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

HB **842** **(CS#1)** Medicaid Waiver Protections/Military Families.

Draft Number:	H842-PCS10568-TR-11
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

Report 1 of 2

Senator Tamara Barringer will handle HB 424
Senator Louis Pate will handle HB 842

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Hise, Co-Chair
Senator Pate, Co-Chair
Senator Tucker, Co-Chair

Friday, June 24, 2016

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

FAVORABLE

HB **1033 (CS#1)** ID Card Fee Waiver/Disability.

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

TOTAL REPORTED: 1

Committee Clerk Comments:

Report 2 of 2

Senator Ralph Hise will handle HB 1033

HOUSE BILL 424:
Prohibit Unlawful Custody Transfer of Child.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 23, 2016
Introduced by:	Reps. Stevens, Glazier	**Prepared by:**	Jan Paul, Staff Attorney
Analysis of:	PCS to Second Edition H424-CSSH-78		

SUMMARY: ***The Proposed Committee Substitute (PCS) for Senate Bill 652 would prohibit the unlawful transfer of custody of a minor child.***

BILL ANALYSIS:

Section 1 of the PCS would create a new G.S. 14-321.2 in the criminal law to do the following:

- Make it a criminal offense for:
  - A parent to effect or attempt to effect an unlawful transfer of custody of that parent's minor child.
  - A person to accept or attempt to accept custody pursuant to an unlawful custody transfer except when the person promptly notifies law enforcement or child protective services.
  - A person to advertise, recruit, or solicit, or aid, abet, conspire or seek the assistance of another to effect the unlawful custody transfer of a minor.
- Define "unlawful transfer of custody" as the permanent transfer of physical custody of a minor child by the child's parent, without a court order or other authorization under law, to a person other than a relative or other individual having a substantial relationship with the child.
  - "Relative" is defined as the child's other parent, stepparent, grandparent, adult sibling, aunt, uncle, first cousin, great-aunt, great-uncle, great-grandparent, or a parent's first cousin.
- Specify that compensation is not required for an unlawful custody transfer to occur.
- Provide that unlawful custody transfer does not include placement of a minor pursuant to specified statutes, temporary placement of a child under specified circumstances, or placement with a prospective adoptive parent consistent with applicable adoption laws.
- Make a violation of the offense a Class A1 misdemeanor; however, a violation that results in serious physical injury to the child is punishable as a Class G felony.

Section 2 would clarify that the prohibition against advertising adoptions by "other public medium" includes email, the Internet, and other similar forms of communication. [G.S. 48-10-101(b).]

Sections 3 and 4 would make conforming changes to statutes in the Juvenile Code.

Section 5 requires the Department of Health and Human Services to collect data on the incidence of disrupted adoptions and unlawful transfer of custody of children in North Carolina and the outcomes for

children and families associated with disrupted adoptions, and shall develop a program to provide needed supports to families at risk of adoption disruptions in order to keep families together.

EFFECTIVE DATE: Sections 1, 3, and 4 of this act become effective December 1, 2015, and apply to offenses committed on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 424
Second Edition Engrossed 6/9/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H424-CSSH-78 [v.4]
06/23/2016 05:12:24 PM

Short Title: Prohibit Unlawful Custody Transfer of Child. (Public)

Sponsors:

Referred to:

April 1, 2015

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE UNLAWFUL TRANSFER OF CUSTODY OF A MINOR CHILD AND TO MAKE CONFORMING STATUTORY CHANGES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 39 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-321.2. Prohibit unlawful transfer of custody of minor child.**

(a) It shall be unlawful for:

(1) A parent to effect or attempt to effect an unlawful transfer of custody of that parent's minor child.

(2) A person to accept or attempt to accept custody pursuant to an unlawful transfer of custody of a minor child; except that it shall not be unlawful for a person to receive custody of a child from a parent who intends to effect an unlawful transfer of custody of that parent's minor child if the person promptly notifies law enforcement or child protective services in the county where the child resides or is found and promptly makes the child available to law enforcement or child protective services.

(3) A person to advertise, recruit, or solicit, or to aid, abet, conspire, or seek the assistance of another to advertise, recruit, or solicit the unlawful transfer of custody of a minor child.

(b) **Definitions.** — As used in this section, the following definitions apply:

(1) "Minor child" means a child under the age of 18 and includes an adopted minor child, as defined in G.S. 48-1-101(14a).

(2) "Parent" means a biological parent, adoptive parent, legal guardian, or legal custodian.

(3) "Relative" means the child's other parent, stepparent, grandparent, adult sibling, aunt, uncle, first cousin, great-aunt, great-uncle, great-grandparent, or a parent's first cousin.

(4) "Unlawful transfer of custody" means the permanent transfer of physical custody of a minor child, in willful violation of applicable adoption law or by grossly negligent omission in the care of the child, by the child's parent, without a court order or other authorization under law, to a person other than a relative or another individual having a substantial relationship with the child. Compensation in the form of money, property, or other item of value is not

required in order for an unlawful transfer of custody to occur. Unlawful transfer of custody does not include any of the following:

a. Placement of a minor child with a prospective adoptive parent in accordance with Part 2 of Article 3 of Chapter 48 of the General Statutes.

b. A consent to adoption of a minor child in accordance with Part 6 of Article 3 of Chapter 48 of the General Statutes.

c. Relinquishment of a minor child in accordance with Part 7 of Article 3 of Chapter 48 of the General Statutes.

d. Placement of a minor child in accordance with the Interstate Compact on the Placement of Children under Article 38 of Chapter 7B of the General Statutes or the Convention of 29 May 1993 on Protection of Children and Co-operation in respect of Intercountry Adoption.

e. Temporary transfer of physical custody of a minor child to an individual with a prior substantial relationship with the child for a specified period of time due to (i) the child's medical, mental health, educational, or recreational needs, or (ii) the parent's inability to provide proper care or supervision for the minor child, which may be due to the parent's incarceration, military service, employment, medical treatment, incapacity, or other voluntary or involuntary absence.

f. Transfer of physical custody or a minor child to a relative.

g. Temporary transfer of physical custody of a minor child to a behavioral health facility or other health care provider, an educational institution, or a recreational facility by a parent for a specified period of time due to the child's medical, mental health, educational, or recreational needs.

h. A voluntary foster care placement of the minor child made pursuant to an agreement between the minor child's parent and a county department of social services as described in G.S. 7B-910.

i. Placement of a minor child with a prospective adoptive parent in substantial compliance with the applicable adoption laws of this State or of another state.

(c) Any person who commits an offense under subsection (a) is guilty of a Class A1 misdemeanor.

(d) Any person who commits an offense under subsection (a) that results in serious physical injury to the child is guilty of a Class G felony. "

SECTION 2. G.S. 48-10-101(b) reads as rewritten:

"(b) No one other than a county department of social services, an adoption facilitator, or an agency licensed by the Department in this State may advertise in any periodical or newspaper, or by radio, television, or other public medium, that any person or entity will place or accept a child for adoption. For purposes of this section, "other public medium" includes the use of any computerized system, including electronic mail, Internet site, Internet profile, or any similar medium of communication provided via the Internet."

SECTION 3. G.S. 7B-101(15) reads as rewritten:

"**§ 7B-101. Definitions.**

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

...

(15) Neglected juvenile. – A juvenile who does not receive proper care, supervision, or discipline from the juvenile's parent, guardian, custodian, or caretaker; or who has been abandoned; or who is not provided necessary medical care; or who is not provided necessary remedial care; or who lives in an environment

injurious to the juvenile's welfare; or the custody of whom has been unlawfully transferred under G.S. 14-321.2; or who has been placed for care or adoption in violation of law. In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died as a result of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse or neglect by an adult who regularly lives in the home."

SECTION 4. G.S. 7B-302(a) reads as rewritten:

"(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough assessment, using either a family assessment response or an investigative assessment response, in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the assessment. When the report alleges neglect or dependency, the director shall initiate the assessment within 72 hours following receipt of the report. When the report alleges ~~abandonment,~~abandonment of a juvenile or unlawful transfer of custody under G.S. 14-321.2, the director shall immediately initiate an ~~assessment, -~~assessment. When the report alleges abandonment, the director shall also take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The assessment and evaluation shall include a visit to the place where the juvenile resides, except when the report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes. When a report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes, a visit to the place where the juvenile resides is not required. When the report alleges abandonment, the assessment shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child."

SECTION 5. The Department of Health and Human Services shall collect data on the incidence of disrupted adoptions and unlawful transfer of custody of children in North Carolina and the outcomes for children and families associated with disrupted adoptions, and shall develop a program to provide needed supports to families at risk of adoption disruptions in order to keep families together.

SECTION 6. Sections 1, 3, and 4 of this act become effective December 1, 2016, and apply to offenses committed on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 424*
Second Edition Engrossed 6/9/15

Short Title:	Fostering Success.	(Public)
Sponsors:	Representatives Stevens and Glazier (Primary Sponsor). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Judiciary III.	

April 1, 2015

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE PROVISION OF FOSTER CARE TO THE AGE OF NINETEEN YEARS AND MAKE VARIOUS CONFORMING STATUTORY CHANGES; AUTHORIZE THE SOCIAL SERVICES COMMISSION TO ADOPT RULES IMPLEMENTING THE EXPANSION OF FOSTER CARE THROUGH AGE NINETEEN; PROVIDE FOR THE EXTENSION OF GUARDIANSHIP SERVICES THROUGH AGE NINETEEN; REQUIRE THE SUBMISSION OF A STATE PLAN AMENDMENT TO DRAW DOWN FEDERAL IV-E FUNDS FOR THE EXPANSION OF FOSTER CARE THROUGH AGE NINETEEN; AND APPROPRIATE FUNDS TO IMPLEMENT THE PURPOSES OF THIS ACT.

Whereas, national research documents the long-term benefits to youth of completing high school, including decreased unemployment rates, decreased reliance on public assistance, decreased rates of incarceration, increased lifetime earnings, improved health choices, and better education outcomes of subsequent generations; and

Whereas, these benefits increase even more with any postsecondary education attainment; and

Whereas, national research has demonstrated that the increase in postsecondary educational attainment associated with allowing foster youth to remain in care until they are 21 years old, and the resulting increase in lifetime earnings associated with postsecondary education means an estimated two-dollar increase in lifetime earnings for every dollar spent on keeping foster youth in care beyond age 18; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-48 reads as rewritten:

"**§ 108A-48. State Foster Care Benefits Program.**

(a) The Department is authorized to establish a State Foster Care Benefits Program with appropriations by the General Assembly for the purpose of providing assistance to children who are placed in foster care facilities by county departments of social services in accordance with the rules and regulations of the Social Services Commission. Such appropriations, together with county contributions for this purpose, shall be expended to provide for the costs of keeping children in foster care facilities.

(b) ~~No benefits provided by this section shall be granted to any individual who has passed his eighteenth birthday unless he is less than 21 years of age and is a full-time student or has been accepted for enrollment as a full-time student for the next school term pursuing a high school diploma or its equivalent; a course of study at the college level; or a course of vocational or technical training designed to fit him for gainful employment.~~The Department may continue

to provide benefits pursuant to this section to an individual who has attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this subsection due to a medical condition or disability."

SECTION 2. G.S. 108A-49.1 reads as rewritten:

"**§ 108A-49.1. Foster care and adoption assistance payment rates.**

(a) The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children 13 through ~~18~~ 19 years of age.

(b) The maximum rates for the State adoption assistance program are established consistent with the foster care rates as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children 13 through ~~18~~ 19 years of age.

(c) The maximum rates for the State participation in human immunodeficiency virus (HIV) foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per child per month with indeterminate HIV status.

(2) $1,000 per child per month with confirmed HIV infection, asymptomatic.

(3) $1,200 per child per month with confirmed HIV infection, symptomatic.

(4) $1,600 per child per month when the child is terminally ill with complex care needs.

In addition to providing board payments to foster and adoptive families of HIV-infected children, any additional funds remaining that are appropriated for purposes described in this subsection shall be used to provide medical training in avoiding HIV transmission in the home.

(d) The State and a county participating in foster care and adoption assistance shall each contribute fifty percent (50%) of the nonfederal share of the cost of care for a child placed by a county department of social services or child-placing agency in a family foster home or residential child care facility. A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for a child placed in a family foster home or residential child care facility under an agreement with that provider as of October 31, 2008, until the child leaves foster ~~care or~~care, experiences a placement ~~change.~~change, or, if after attaining the age of 18 years, the child chooses to continue receiving foster care or guardianship services to age 19 years as provided by law."

SECTION 3. G.S. 131D-10.2 reads as rewritten:

"**§ 131D-10.2. Definitions.**

For purposes of this Article, unless the context clearly implies otherwise:

...

(3) "Child" means an individual less than ~~18~~ 19 years of age, who has not been emancipated under the provisions of Article 35 of Chapter 7B of the General Statutes.

...

(9a) "Foster Parent" means any individual who is ~~18~~ 19 years of age or older who is licensed by the State to provide foster care.

...."

SECTION 4. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Foster care through 19 years of age.**

(a) A child placed in foster care who has attained the age of 18 years may continue receiving foster care services to age 19 years as provided by law. A child who initially chooses to opt out of foster care upon attaining the age of 18 years may opt to receive foster care services at a later date up to 19 years of age.

(b) A child who has attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age may continue to receive benefits pursuant to Part 4 of Article 2 of Chapter 108A of the General Statutes upon meeting the requirements under G.S. 108A-48(b)."

SECTION 5. G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this ~~Article;~~Article.

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this ~~Article;~~Article.

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking ~~licenses;~~licenses.

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article;~~Article.

(5) Adopt rules on documenting the use of physical restraint in residential child-care ~~facilities;~~facilities.

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care ~~facilities; and~~facilities.

(7) Adopt rules establishing educational requirements, minimum age, relevant experience, and criminal record status for executive directors and staff employed by child placing agencies and residential child care facilities.

(8) Adopt any rules necessary for the expansion of foster care for individuals who have attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age in accordance with G.S. 131D-10.2A."

SECTION 6.(a) The Department of Health and Human Services, Division of Social Services, (Division) shall develop a plan for the expansion of foster care services for individuals who have attained the age of 18 years and opt to continue receiving foster care services to 19 years of age. The Division shall report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015. The Division shall report on the plan as implemented to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016.

SECTION 6.(b) No later than 60 days after the Department implements the plan for the expansion of foster care services as required under subsection (a) of this section, the Division shall submit a state plan amendment to the U.S. Department of Health and Human Services Administration for Children and Families to make federal payments for foster care and adoption assistance, as applicable, under Title IV-E, available to a person meeting the requirements of G.S. 108A-48(b), as enacted in Section 1 of this act.

SECTION 7. Regarding the provision of foster care services, the Department of Health and Human Services, Division of Social Services, may provide for the financial support

of children who are deemed to be (i) in a permanent family placement setting, (ii) eligible for legal guardianship, and (iii) otherwise unlikely to receive permanency. The Division of Social Services shall design the Guardianship Assistance Program (GAP) to include provisions for extending guardianship services for individuals who have attained the age of 18 years and opt to continue to receive guardianship services to age 19 years if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this section due to a medical condition or disability. The Guardianship Assistance Program rates shall reimburse the legal guardian for room and board and be set at the same rate as the foster care room and board rates in accordance with rates established under G.S. 108A-49.1. The Social Services Board shall adopt rules establishing a Guardianship Assistance Program to implement this section, including defining the phrase "legal guardian" as used in this section.

SECTION 8. This act becomes effective August 1, 2016.

HOUSE BILL 1033:
ID Card Fee Waiver/Disability.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 23, 2016
Introduced by:	Reps. Hardister, Lewis, Avila, Bryan	**Prepared by:**	Augustus Willis
Analysis of:	Third Edition		Committee Counsel

SUMMARY: House Bill 1033 would add persons who have developmental disabilities to the list of persons for whom the $13.00 application fee to obtain a special identification card is waived.

CURRENT LAW: G.S. 20-37.7 governs the issuance of special identification cards. Any person who is a resident of North Carolina is eligible for a special identification card and, unless an exemption applies pursuant to 20-37.7(d), a person must pay an application fee of thirteen dollars ($13.00). The current list of exemptions require the applicant to be one of the following:

- Blind;
- At least 70 years old;
- Physically or mentally disabled, which caused a cancellation of the applicant's driver's license;
- Homeless;
- Registered to vote in North Carolina with no acceptable photo identification; or
- Attempting to register to vote in North Carolina with no acceptable photo identification.

BILL ANALYSIS: House Bill 1033 would add another exemption from the special identification card application fee for those who can demonstrate via a primary care provider's letter to the Division of Motor Vehicles that they have a developmental disability. The term "developmental disability" is defined under G.S. 122C-3(12a) to mean a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated; or
- When applied to children from birth through four years of age, may be evidenced as a developmental delay.

Karen Cochrane-Brown
Director

H1033-SMTY-53 E3 -V-3

Legislative Analysis
Division
919-733-2578

EFFECTIVE DATE: This act would become effective October 1, 2016 and apply to special identification cards issued on or after that date.

** Nicholas Giddings, co-counsel to House Finance, contributed substantially in the preparation of this bill summary.*

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 3

HOUSE BILL 1033
Committee Substitute Favorable 6/16/16
Third Edition Engrossed 6/20/16

Short Title: ID Card Fee Waiver/Disability. (Public)

Sponsors:

Referred to:

May 5, 2016

A BILL TO BE ENTITLED

AN ACT TO WAIVE THE FEE FOR A SPECIAL IDENTIFICATION CARD ISSUED TO A PERSON WITH A DEVELOPMENTAL DISABILITY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-37.7(d) reads as rewritten:

"(d) Expiration and Fee. – A special identification card issued to a person for the first time under this section expires when a drivers license issued on the same day to that person would expire. A special identification card renewed under this section expires when a drivers license renewed by the card holder on the same day would expire.

The fee for a special identification card is the same as the fee set in G.S. 20-14 for a duplicate license. The fee does not apply to a special identification card issued to a resident of this State as follows:

...

(6) The applicant is appearing before the Division for the purpose of registering to vote in accordance with G.S. 163-82.19 and does not have other photo identification acceptable under G.S. 163-166.13. To obtain a special identification card without paying a fee, that applicant shall sign a declaration stating that applicant is registering to vote and does not have other photo identification acceptable under G.S. 163-166.13. Any declaration shall prominently include the penalty under G.S. 163-275(13) for falsely making the declaration.

(7) The applicant has a developmental disability. To obtain a special identification card without paying a fee pursuant to this subdivision, an applicant must present a letter from his or her primary care provider certifying that the applicant has a developmental disability. For purposes of this subdivision, the term "developmental disability" has the same meaning as in G.S. 122C-3."

SECTION 2. This act becomes effective October 1, 2016, and applies to special identification cards issued on or after that date.

HOUSE BILL 1033
Committee Substitute Favorable 6/16/16

Short Title: ID Card Fee Waiver/Disability. (Public)

Sponsors:

Referred to:

May 5, 2016

A BILL TO BE ENTITLED

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The fee for a special identification card is the same as the fee set in G.S. 20-14 for a duplicate license. The fee does not apply to a special identification card issued to a resident of this State as follows:

...

(6) The applicant is appearing before the Division for the purpose of registering to vote in accordance with G.S. 163-82.19 and does not have other photo identification acceptable under G.S. 163-166.13. To obtain a special identification card without paying a fee, that applicant shall sign a declaration stating that applicant is registering to vote and does not have other photo identification acceptable under G.S. 163-166.13. Any declaration shall prominently include the penalty under G.S. 163-275(13) for falsely making the declaration.

(7) The applicant has a developmental disability. To obtain a special identification card without paying a fee pursuant to this subdivision, an applicant must present a letter from his or her physician certifying that the applicant has a developmental disability. For purposes of this subdivision, the term "developmental disability" has the same meaning as in G.S. 122C-3."

SECTION 2. This act becomes effective October 1, 2016, and applies to special identification cards issued on or after that date.

HOUSE BILL 842:
Medicaid Waiver Protections/Military Families.

2016-2017 General Assembly

Committee:	Senate Health Care	**Date:**	June 24, 2016
Introduced by:	Reps. G. Martin, Avila, Adcock	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Second Edition H842-CSTR-11		

SUMMARY: ***The PCS to House Bill 842 would require the Department of Health and Human Services (DHHS) to ensure that the eligibility criteria for Medicaid home- and community-based waivers allow a dependent of a member of the Armed Forces to maintain the dependent's waiver status upon transfer of the service member to an assignment outside of North Carolina, so long as the member maintains North Carolina as the legal residence to which the member intends to return upon completion of military service.***

CURRENT LAW: In accordance with federal law, North Carolina residents meeting Medicaid eligibility criteria are eligible for Medicaid state plan services. As permitted under federal law, individuals requiring an institutional level of care may be eligible for additional home and community-based services through a Medicaid waiver program. North Carolina operates three home and community-based waiver programs serving individuals with developmental disabilities, disabled adults, and medically fragile children. Due to waiver funding restrictions, there are a limited number of slots for individuals to be served through a waiver program, and a waiting list of individuals who have requested a slot is maintained.

BILL ANALYSIS:

Section 1 of the PCS would require the Department of Health and Human Services (DHHS) to ensure that a dependent of a member of the Armed Forces maintains his or her position on the waiting list for a waiver slot when the service member is transferred to an assignment outside of North Carolina, as long as the service member intends to return to North Carolina upon completion of the military service. If a dependent of a service member was receiving waiver services prior to the transfer out of North Carolina, then upon return to North Carolina, the dependent shall be reinstated to his or her slot, if it remains available, or receive a priority position on the waiting list for the next available slot. Upon return to North Carolina, the dependent must meet Medicaid eligibility requirements and all other waiver eligibility requirements.

Section 2 of the PCS would require DHHS to submit any Medicaid State Plan amendments or waiver amendments necessary to implement the act.

EFFECTIVE DATE: Section 1 of this bill would become effective January 1, 2017, and the remainder of the bill would become effective when the bill becomes law.

Karen Cochrane-Brown
Director

H842-SMTR-22 CSTR-11 -V-1

Legislative Analysis
Division
919-733-2578

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H D

HOUSE BILL 842
Committee Substitute Favorable 4/23/15
PROPOSED SENATE COMMITTEE SUBSTITUTE H842-CSTR-11 [v.1]
06/23/2016 02:47:49 PM

Short Title: Medicaid Waiver Protections/Military Families. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO PROTECT ACCESS TO MEDICAID WAIVERS BY DEPENDENTS OF MEMBERS OF THE ARMED FORCES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall ensure that the eligibility criteria for Medicaid home- and community-based waivers allow the dependent of a member of the Armed Forces to maintain the dependent's waiver status upon the transfer of the service member to an assignment outside of North Carolina, so long as the service member maintains the State of North Carolina as the legal residence to which the service member intends to return following completion of military service, and the dependent meets Medicaid eligibility criteria and all other waiver eligibility criteria upon returning to North Carolina. Consequently, a dependent who is on the waiting list for a waiver slot shall maintain the dependent's position on the waiting list. A dependent who was receiving waiver services prior to the service member's transfer, upon the dependent's return to North Carolina, shall be reinstated to the dependent's waiver slot, if the slot remains available, or shall receive a priority position on the waiting list for the next available waiver slot. This section shall not be construed to authorize the provision of waiver services outside of North Carolina.

SECTION 2. The Department of Health and Human Services shall submit any Medicaid State Plan Amendments or waiver amendments necessary to accomplish the requirements in Section 1 of this act.

SECTION 3. Section 1 of this act becomes effective January 1, 2017. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2015

H 2

HOUSE BILL 842
Committee Substitute Favorable 4/23/15

Short Title: Medicaid Waiver Protections/Military Families. (Public)

Sponsors:

Referred to:

April 15, 2015

A BILL TO BE ENTITLED

AN ACT TO PROTECT ACCESS TO MEDICAID WAIVERS BY DEPENDENTS OF MEMBERS OF THE ARMED FORCES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall ensure that the eligibility criteria for Medicaid home- and community-based waivers allow the dependent of a member of the Armed Forces to maintain the dependent's waiver status upon the transfer of the service member to an assignment outside of North Carolina, so long as the service member maintains the State of North Carolina as the legal residence to which the service member intends to return following completion of military service, and the dependent meets Medicaid eligibility criteria and all other waiver eligibility criteria upon returning to North Carolina. Consequently, a dependent who is on the waiting list for a waiver slot would maintain the dependent's position on the waiting list. A dependent who was receiving waiver services prior to the service member's transfer, upon the dependent's return to North Carolina, would be reinstated to the dependent's waiver slot, if the slot remains available, or would receive a priority position on the waiting list for the next available waiver slot. This section shall not be construed to authorize the provision of waiver services outside of North Carolina.

SECTION 2. The Department of Health and Human Services shall submit any Medicaid State Plan Amendments or waiver amendments necessary to accomplish the requirements in Section 1 of this act.

SECTION 3. Section 1 of this act becomes effective January 1, 2016. The remainder of this act is effective when it becomes law.

OFFICE OF THE DEPUTY ASSISTANT SECRETARY OF DEFENSE
(MILITARY COMMUNITY AND FAMILY POLICY)
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

DoD-State Liaison Office

Letter of Support to North Carolina House Health Committee HB 842, Medicaid Waiver Protections for Military Families

by Kevin Bruch

April 21, 2015

Honorable Chairman Brown and members of the House Health Committee, thank you for this opportunity to provide support for the policy language represented in House Bill 842. This will allow Service Members to retain their earned priority for receiving Medicaid Home and Community Based Services Waivers. The Department of Defense thinks this will greatly help military families with special needs dependents who are North Carolina residents when they return from military service back to their home state.

My name is Kevin Bruch, retired Air Force Chief Master Sergeant and now the Department of Defense (DoD) South Atlantic Region Liaison for four states, working for the Deputy Assistant Secretary of Defense for Military Community and Family Policy.

Individual state Medicaid eligibility requirements and lengthy waiting lists hinder transient military families from obtaining supplemental support services for their children with special needs. This is especially true when they are transitioning out of the military with potentially uncertain medical coverage and gaps in services.

The Department of Defense established the TRICARE ECHO program to provide $36,000 of additional coverage for active duty sponsored family members with condition-specific needs; however, they lose ECHO support upon separation/retirement from the military.

States can assist separating Service members and their families by recognizing that the mobile military lifestyle hinders reasonable participation in state Medicaid options and waiver programs.

- HB 842 will help ease this burden on our military families. Eligibility status is retained as long as the member maintains the state as his/her legal resident and returns to the state after military separation. The member either receives credit for time on the list or begins receiving benefits when they return home.

The policy as represented in HB 842 would help those families by enabling them to earn the same priorities afforded to every state resident, requiring them to apply for services. We would also expect the Service member to maintain current contact information while out of state on military orders.

We believe this initiative is fiscal neutral in that the eligible family member would only receive those services for which they would be otherwise eligible had they remained in the state.

Since our introduction and advocacy of this issue in the states in 2014, the states of Washington, Alaska, Illinois, South Carolina, and Florida have begun providing this opportunity to our military families. Another 10 states have legislation pending in this session.

In conclusion, we are not asking to create a special group of people in this effort. We are asking the state to maintain the benefits extended to all qualified residents, but enable those residents in the military to maintain their earned eligibility status in North Carolina until they can return home to use it. The Department requests that you allow these families to apply for benefits in the same manner as any other resident of the state, without priority processing, without special benefits, and without any special treatment to convey a perceived privilege.

We thank Representatives Martin, Avila and Adcock for sponsoring this initiative. Thank you for taking up this issue in the House of Representatives and for your consideration.

If there are any questions I can be reached at:

Kevin Bruch
South Atlantic Region Liaison (GA, NC, SC, VA)
571-309-8443
Mark.k.bruch.civ@mail.mil

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 24, 2016

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09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 24, 2016

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Senate Committee on Health Care

June 24, 2016

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Senate Committee on Health Care

June 24, 2016

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