2017-2018

SENATE
HEALTH CARE

MINUTES

Senate Committee on Health Care
Wednesday, March 8 at 10:00am
Room 643

MINUTES

The Senate Committee on Health Care met at 10:00am on March 8 in Room 643. Eighteen members were present.

Senator Louis M. Pate, Jr. presided.

Senator Pate welcomed everyone and recognized the Senate Segeants-at-Arms --- Terry Barnhardt, Linda Matthews, Larry Hancock, and Sham Patel. He also recognized the Senate Pages --- Seth Heathman of Stanly County, Andrew Beck of Stanly County, and Isaiah McIe of Stanly County.

Senator Hise presented Senate Bill 42, Reduce Cost & Reg. Burden/Hosp. Construction. After discussion on the bill, Senator Hise presented an amendment to Senate Bill 42. Senator Tucker motioned for a favorable report on the bill as amended, and Senate Bill 42 as amended was referred to Committee on Rules and Operations of the Senate.

The meeting adjourned at 10:55am.

Louis M Pate Jr.

Senator Louis M. Pate, Jr.
Presiding

Sinclaire Owen, Committee Clerk

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	March 8, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 42	Reduce Cost & Reg. Burden/Hosp. Construction.	Senator Hise Senator Krawiec Senator Pate

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

SENATE BILL 42:
Reduce Cost & Reg. Burden/Hosp. Construction.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 8, 2017
Introduced by:	Sens. Hise, Krawiec, Pate	**Prepared by:**	Jennifer Mundt Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 42 would direct the North Carolina Medical Care Commission to adopt the recommendations of the American Society of Healthcare Engineers Facility Guidelines Institute.

CURRENT LAW: The North Carolina Medical Care Commission adopts and implements rules for hospital licensure. The rules in 10A NCAC 13B .6000 et. seq. include physical plant and construction requirements for hospital facilities.

BILL ANALYSIS: Senate Bill 42 would do the following:

- Direct the Medical Care Commission to repeal a suite of rules that regulate licensing of hospitals pertaining to physical plant, general requirements, and construction requirements (Hospital Facilities Rules) within 120 days of the act becoming law.
- Direct the Commission to replace those particular rules with temporary (and subsequently permanent) rules by incorporating, by reference, all the applicable standards, rules, and requirements of the most current edition of the American Society for Healthcare Engineering's Facility Guidelines Institute *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* (Guidelines).
- Provide that the rules adopted to replace the Hospital Facilities Rules with the Guidelines would be exempt from the provisions of the Administrative Procedure Act (Act) under Chapter 150B of the General Statutes that require the preparation of fiscal notes.
- Provide that until the Hospital Facilities Rules are repealed and replaced by the Guidelines, the Hospital Facilities Rules would not be subject to the statutory periodic rules review required by the Act.

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

BACKGROUND: According to the American Hospital Association and the American Society for Healthcare Engineering, the *Guidelines for Design and Construction of Hospitals and Outpatient Facilities* provide minimum standards for design and construction of hospitals and outpatient facilities. Included in the *Guidelines* is information on the planning, design, construction, and commissioning process and facility requirements for both hospitals and outpatient facilities.

Erin Cochrane-Brown
Director

S42-SMTA-4 E1 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

SENATE BILL 42

Short Title:	Reduce Cost & Reg. Burden/Hosp. Construction.	(Public)
Sponsors:	Senators Hise, Krawiec, and Pate (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

February 8, 2017

A BILL TO BE ENTITLED

AN ACT DIRECTING THE MEDICAL CARE COMMISSION TO ADOPT THE RECOMMENDATIONS OF THE AMERICAN SOCIETY OF HEALTHCARE ENGINEERING'S FACILITY GUIDELINES INSTITUTE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Definitions. – For purposes of this section and its implementation:

(1) Commission or Medical Care Commission. – The Medical Care Commission created by Part 10 of Article 3 of Chapter 143B of the General Statutes.

(2) Hospital Facilities Rules. – Means all of the following:

a. 10A NCAC 13B .6001 – Physical Plant: Location.
b. 10A NCAC 13B .6002 – Physical Plant: Roads and Parking.
c. 10A NCAC 13B .6104 – General Requirements: Access and Safety.
d. 10A NCAC 13B .6201 – Construction Requirements: Medical, Surgical, and Post-Partum Care Unit.
e. 10A NCAC 13B .6202 – Construction Requirements: Special Care Unit.
f. 10A NCAC 13B .6203 – Construction Requirements: Neonatal Level I and Level II Nursery Unit.
g. 10A NCAC 13B .6204 – Construction Requirements: Neonatal Level III and Level IV Nursery.
h. 10A NCAC 13B .6205 – Construction Requirements: Psychiatric Unit.
i. 10A NCAC 13B .6206 – Construction Requirements: Surgical Department Requirements.
j. 10A NCAC 13B .6207 – Construction Requirements: Obstetrical Department Requirements.
k. 10A NCAC 13B .6209 – Construction Requirements: Emergency Services.
l. 10A NCAC 13B .6210 – Construction Requirements: Imaging Services.
m. 10A NCAC 13B .6211 – Construction Requirements: Laboratory Services.
n. 10A NCAC 13B .6212 – Construction Requirements: Morgue.
o. 10A NCAC 13B .6213 – Construction Requirements: Pharmacy Services.
p. 10A NCAC 13B .6214 – Construction Requirements: Dietary Services.
q. 10A NCAC 13B .6215 – Construction Requirements: Administration.
r. 10A NCAC 13B .6216 – Construction Requirements: Medical Records Services.

s. 10A NCAC 13B .6217 – Construction Requirements: Central Medical and Surgical Supply Services.
t. 10A NCAC 13B .6218 – Construction Requirements: General Storage.
u. 10A NCAC 13B .6219 – Construction Requirements: Laundry Services.
v. 10A NCAC 13B .6220 – Construction Requirements: Physical Rehabilitation Services.
w. 10A NCAC 13B .6221 – Construction Requirements: Engineering Services.
x. 10A NCAC 13B .6222 – Construction Requirements: Waste Processing.
y. 10A NCAC 13B .6223 – Construction Requirements: Details and Finishes.
z. 10A NCAC 13B .6224 – Construction Requirements: Elevator Requirements.
aa. 10A NCAC 13B .6225 – Construction Requirements: Mechanical Requirements.
bb. 10A NCAC 13B .6226 – Construction Requirements: Plumbing and Other Piping Systems Requirements.
cc. 10A NCAC 13B .6227 – Construction Requirements: Electrical Requirements.

(3) Guidelines. – The American Society for Healthcare Engineering's Facility Guidelines Institute "Guidelines for Design and Construction of Hospitals and Outpatient Facilities."

SECTION 1.(b) Repeal Hospital Facilities Rules. – The Secretary of Health and Human Services and the Medical Care Commission shall repeal the Hospital Facilities Rules within 120 days after this act becomes law.

SECTION 1.(c) Implementation and Rule-Making Authority. – Before the effective date of the repeal of the Hospital Facilities Rules required pursuant to subsection (b) of this section, the Medical Care Commission shall adopt temporary rules to replace the Hospital Facilities Rules and incorporate by reference all applicable rules, standards, and requirements of the most current edition of the Guidelines. If temporary rules are not adopted before the repeal of the Hospital Facilities Rules required pursuant to subsection (a) of this section, the Commission shall utilize the 2014 Edition of the Guidelines until such time as temporary rules are adopted. Furthermore, the Commission shall adopt permanent rules pursuant to this section.

SECTION 1.(d) Additional Rule-Making Authority. – The Medical Care Commission shall adopt rules to replace the Hospital Facilities Rules. Notwithstanding G.S. 150B-19(4), the rules adopted by the Commission pursuant to this section shall conform to the provisions of subsection (c) of this section. Rules adopted pursuant to this section are not subject to Part 3 of Article 2A of Chapter 150B of the General Statutes. Rules adopted pursuant to this section shall become effective as provided in subsection (b1) of G.S. 150B-21.3 as though 10 or more written objections had been received as provided by subsection (b2) of G.S. 150B-21.3. Furthermore, rules adopted pursuant to this section shall be exempt from the provisions of Chapter 150B of the General Statutes that require the preparation of fiscal notes for any rule proposed to incorporate the Guidelines by reference.

SECTION 1.(e) Exemption From Periodic Review. – Until such time as the Hospital Facilities Rules are repealed pursuant to subsection (b) of this section, the Hospital Facilities Rules shall be exempt from the periodic review process required pursuant to G.S. 150B-21.3A.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S D

SENATE BILL 42
PROPOSED COMMITTEE SUBSTITUTE S42-PCS45168-TA-3

Short Title: Reduce Cost & Reg. Burden/Hosp. Construction. (Public)

Sponsors:

Referred to:

February 8, 2017

A BILL TO BE ENTITLED

AN ACT DIRECTING THE MEDICAL CARE COMMISSION TO ADOPT THE RECOMMENDATIONS OF THE AMERICAN SOCIETY OF HEALTHCARE ENGINEERING'S FACILITY GUIDELINES INSTITUTE.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Definitions. – For purposes of this section and its implementation:

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e. 10A NCAC 13B .6202 – Construction Requirements: Special Care Unit.
f. 10A NCAC 13B .6203 – Construction Requirements: Neonatal Level I and Level II Nursery Unit.
g. 10A NCAC 13B .6204 – Construction Requirements: Neonatal Level III and Level IV Nursery.
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i. 10A NCAC 13B .6206 – Construction Requirements: Surgical Department Requirements.
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bb. 10A NCAC 13B .6226 – Construction Requirements: Plumbing and Other Piping Systems Requirements.
cc. 10A NCAC 13B .6227 – Construction Requirements: Electrical Requirements.

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SECTION 1.(b) Repeal Hospital Facilities Rules. – The Secretary of Health and Human Services and the Medical Care Commission shall repeal the Hospital Facilities Rules within 120 days after this act becomes law.

SECTION 1.(c) Implementation and Rule-Making Authority. – Before the effective date of the repeal of the Hospital Facilities Rules required pursuant to subsection (b) of this section, the Medical Care Commission shall adopt temporary rules to replace the Hospital Facilities Rules and incorporate by reference all applicable rules, standards, and requirements of the most current edition of the Guidelines. If temporary rules are not adopted before the repeal of the Hospital Facilities Rules required pursuant to subsection (b) of this section, the Commission shall utilize the 2014 Edition of the Guidelines until such time as temporary rules are adopted. Furthermore, the Commission shall adopt permanent rules pursuant to this section.

SECTION 1.(d) Additional Rule-Making Authority. – The Medical Care Commission shall adopt rules to replace the Hospital Facilities Rules. Notwithstanding G.S. 150B-19(4), the rules adopted by the Commission pursuant to this section shall conform to the provisions of subsection (c) of this section. Rules adopted pursuant to this section are not subject to Part 3 of Article 2A of Chapter 150B of the General Statutes. Rules adopted pursuant to this section shall become effective as provided in subsection (b1) of G.S. 150B-21.3 as though 10 or more written objections had been received as provided by subsection (b2) of G.S. 150B-21.3. Furthermore, rules adopted pursuant to this section shall be exempt from the provisions of Chapter 150B of the General Statutes that require the preparation of fiscal notes for any rule proposed to incorporate the Guidelines by reference.

SECTION 1.(e) Exemption From Periodic Review. – Until such time as the Hospital Facilities Rules are repealed pursuant to subsection (b) of this section, the Hospital Facilities Rules shall be exempt from the periodic review process required pursuant to G.S. 150B-21.3A.

SECTION 2. This act is effective when it becomes law and applies to any licensee or prospective applicant who seeks to make specified types of alterations or additions to its hospital facilities or to construct new hospital facilities and who submits plans and specifications to the Department of Health and Human Services pursuant to Article 5 of Chapter 113E of the General Statutes on or after January 1, 2016.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 42

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

S42-ATA-1 [v.2]

Amends Title [NO]
First Edition

Date March 8 ,2017

Senator Hise

moves to amend the bill on page 2, line 47
by rewriting that line to read:

"**SECTION 2.** This act is effective when it becomes law and applies to any licensee or prospective applicant who seeks to make specified types of alterations or additions to its hospital facilities or to construct new hospital facilities who submits plans and specifications to the Department of Health and Human Services pursuant to Article 5 of Chapter 113E of the General Statutes on or after January 1, 2016."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 8, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Andy Chase	KMA
Padraig Gibbons	Connect C
Pam Bowman RN	Nurse of the Day – Duke Univ. Hospital
[illegible]	BP
Susan R. DeJarnette	ND
Steven C. Lewis	DHSR
Jessie Goodmon	DHHS/DHSR
Corye Dunn	DRNC
Kerian Menard	UM
Sarah McCullam	NCANC
Dana Zillioli	Vista
Anna Shelley	Policy Group
Betsy Bailey	CAGC
Henry Jones	PHCC/CECH
BILL SLOGGIN	TS
Michelle Frazier	SML
Cher McDonald	KTS

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 8, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Scott Lastor	KGA&C
Tracy Kimbrell	Parker Poe
Martha McConnell	Carolina Health Care
Lori Kroll	Novant Health
Emily Ziegler	UNC REX

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 8, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Brian Perkins	Alliance BHC
Sara Lopez	BCBSNC
	CSS
Joyce Peters	CSS
Abby Emerson	NMSS
Brittan Blumm	NMSS
Mary Jane	BSC
Amanda Donovan	TSS
Steve Metcalf	The Policy Group
Chris Brayton	MLG
Jeremy Cothen	NM
Ben Popkin	DHHS
Mike James	DCP
Crystal Feldman	Smith Anderson
Karen Weishaar	Smith Anderson
Ceay Hand	NCHA

09-21-201

Senate Committee on Health Care
Wednesday, March 15, 2017, at 10:00 AM
Room 643

MINUTES

The Senate Committee on Health Care met at 10:00 on March 15th, 2017 in Room 643. Fourteen members were present.

Senator Ralph Hise presided.

Senator Hise welcomed everyone and recognized the Senate Segeants-at-Arms --- Terry Barnhardt, Larry Hancock, and Giles Jeffreys. He also recognized the Senate Pages --- Alyssa Alfaro of Wayne County, Emily Willis of Wake County, Diana Jasany of Iredell County, Jillian Jessup of Wake County, Katie Grush of Wake County, and Grayson Burnett of Brunswick County.

Senator J. Davis presented Senate Bill 175, Strengthen Opioid Misuse Prevention (STOP) Act. Two members of the public, Marsha Gintis and Cathy Pietro, shared personal stories about how opioid addiction had negatively impacted their families. Two lobbyists, Chip Baggett of North Carolina Medical Society and Rob Lammé of Rob Lammé & Associates, spoke in support of the bill. Senate Bill 175 was for discussion only.

Senator Hise requested a motion to take up the matter of issuing a subpoena to Mandy Cohen. Senator Newton made the motion to bring up the matter of subpoenaing Mandy Cohen before the committee and offered a draft subpoena. After debate and discussion, Senator Pate made the final motion for a vote of the committee. Senator Hise noted that eleven members of the committee voted Aye and two voted No. The motion to subpoena Mandy Cohen passed.

The meeting adjourned at 11:00 AM.

Senator Ralph Hise
Presiding

Sinclaire Owen, Committee Clerk

Principal Clerk ____
Reading Clerk ____

Corrected #1:

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	March 15, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 175	Strengthen Opioid Misuse Prevention (STOP)Act. For discussion only	Senator J. Davis Senator McInnis Senator Rabon

Consider issuance of subpeona to Many Cohen for appearance at committee meeting

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

Senate Committee on Health Care
Wednesday, March 15, 2017, 10:00 AM
643

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 175	Strengthen Opioid Misuse Prevention (STOP)Act.	Senator J. Davis Senator McInnis Senator Rabon

Other Business

Consider issuance of subpoena to Mandy Cohen for appearance at committee meeting.

Adjournment

SENATE BILL 175: Strengthen Opioid Misuse Prevention (STOP) Act.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 15, 2017
Introduced by:	Sens. J. Davis, McInnis, Rabon	**Prepared by:**	Augustus D. Willis Jason Moran-Bates Committee Co-Counsel
Analysis of:	First Edition		

OVERVIEW: Senate Bill 175 would (i) extend the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (ii) make changes to the laws for prescribing Schedule II through IV controlled substances, (iii) clarify the allowable funds for syringe exchange programs, (iv) make changes to the statutes governing the Controlled Substance Reporting System (CSRS) database, and (v) appropriate $10 million in each of the next two fiscal years to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse for increasing the availability of community-based treatment and recovery services for substance abuse disorders.

[As introduced, this bill was identical to H243, as introduced by Reps. Murphy, Davis, Malone, and Horn which is currently in House Health.]

BILL ANALYSIS:

Part I. TITLE OF ACT

Section 1 sets forth the title of the act as the Strengthen Opioid Misuse Prevention (STOP) Act of 2017.

Part II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

G.S. 90-12.7 sets forth statutes governing the prescribing of opioid antagonists for treatment of a drug overdose. These statutes allow a practitioner to, either directly or by standing order, prescribe an opioid antagonist to a person at risk of experiencing an opiate-related overdose, or their family member, friend, or other person in a position to assist such a person. In 2016, the General Assembly expanded this to allow the State Health Director to issue prescriptions to such persons by way of a statewide standing order.

Section 2 would amend the statutes on the treatment of overdoses with opioid antagonist to (1) allow the State Health Director to name a designee to prescribe an opioid antagonist by statewide standing order, and (2) allow practitioners to either directly, or by standing order, prescribe an opioid antagonist to any governmental or nongovernmental organization for the purpose of distribution to persons at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist such a person. Any organization distributing the opioid antagonist would be required to include with it basic instruction and information on how to administer it.

This analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

Current law authorizes licensed physician assistants and nurse practitioners to write prescriptions so long as a supervising physician has provided written instructions for prescribing drugs and a written policy for periodic review by the physician of drugs prescribed.

Absent an emergency situation, the dispensing of Schedule II controlled substances generally requires a written prescription, made out no more than 6 months prior to the date the substance is dispensed, with an exception that no prescription is needed if the substance is dispensed directly by a practitioner to an ultimate user. Prescriptions for Schedule II controlled substances may not be refilled. Schedule III and IV controlled substances require a prescription no older than 6 months old and may not be refilled more than five times after the date of the prescription.

Section 3 would amend the statutes authorizing physician assistants to write prescriptions by requiring a physician assistant to consult with the supervising physician prior to prescribing controlled substances included in Schedules II through V if the therapeutic use of the controlled substance will or is expected to exceed a period of 30 days. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the physician assistant must consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.

Section 4 would amend the statutes authorizing nurse practitioners to write prescriptions by including the same requirements in Section 3.

Section 5 would require electronic prescriptions for all controlled substances in Schedules II through V except for prescriptions issued by:

- A practitioner who is dispensing directly to an ultimate user.
- A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility.
- A practitioner who experiences temporary technological or electrical failure that prevents the prescription from being transmitted electronically and the reason for this exception is documented in the patient's medical record.
- A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property and the reason for this exception is documented in the patient's medical record.

Prescriptions for controlled substances included in Schedules II through V would be limited to no more than a 5 day supply upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for immediate post-operative pain relief, in which case the practitioner may not prescribe more than a 7-day supply. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a Schedule II through V controlled substance. Acute pain is defined as pain that the practitioner reasonably expects to last for three months or less and does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder. Chronic pain is defined as pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

Section 6 would require any hospice or palliative care provider who prescribes a Schedule II through V controlled substance to be administered to a patient in the patient's home to make diligent efforts to ensure that any residual portion of the controlled substance is safely disposed of following the death of the patient.

Section 7 would add a new section to Article 51 of Chapter 58 of the General Statutes to require any insurance plan that charges a co-payment for prescription drugs to charge a co-payment for any limited, initial prescription of a Schedule II through Schedule V controlled substance. This co-payment would have to be either proportional to the amount charged for a thirty-day supply and the amount of the substance actually prescribed, or the full rate for a thirty-day supply, so long as no additional co-payment is charged for additional prescriptions of the same substance for the remainder of the thirty-day supply.

PART IV: CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

Section 8 would clarify language in the statute authorizing needle and syringe exchange programs to prohibit the use of State funds to purchase needles, hypodermic syringes, or other injection supplies. Non-State public funds could still be used for this purpose.

PART V: STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

The Controlled Substances Reporting System (CSRS) is a database maintained by the Department of Health and Human Services that tracks prescriptions for Schedule II through V controlled substances. Dispensers are required to report certain information on prescriptions they fill within 3 days after the prescription is delivered, but are encouraged to report such information within 24 hours. Such information is confidential and may only be accessed by certain persons for specific purposes set forth by statute.

Section 9 would make technical changes to the definitions used in the CSRS laws and define the term "pharmacy" as a person or entity who holds a valid pharmacy permit.

Section 10 would require dispensers to report required information within 24 hours of filling a prescription and would require the Department of Health and Human Services to assess civil penalties of up to $250 for a first violation and up to $500 for each subsequent violation, not to exceed $10,000 per pharmacy in a calendar year to pharmacies found to have failed to report required information within a reasonable period of time after being informed that such information is missing or incomplete.

Section 11 would amend the laws governing the confidentiality of CSRS data to allow the Department to notify practitioners of prescribing behavior that increases risk of diversion of controlled substances, increases risk of harm to the patient, or is an outlier among other practitioner behavior.

Section 12 would amend the laws governing the confidentiality of CSRS data to add to the list of persons to whom the Department man release CSRS data (i) any third-party payer or pharmacy benefits manager acting as agent of a third-party payer for the purposes of claimant case management, (ii) detection of inappropriate prescribing of a controlled substance to a claimant, or (iii) detection of misuse or diversion of a controlled substance by a claimant.

Section 13 would add the following new sections to Article 5E of Chapter 90 of the General Statutes governing the CSRS:

- 90-113.74A: would require recipients of new or renewed pharmacist licenses to demonstrate to the NC Board of Pharmacy registration for access to the CSRS within 30 days of licensure.
- 90-113.74B: would require practitioners to review a patient's 12-month history in the CSRS prior to prescribing a Schedule II through Schedule V drug and review the patient's 12-month history in the CSRS every three months while the controlled substance remains part of the patient's medical care plan. These reviews would have to be documented in the patient's medical records, along with the occasion of any CSRS outage that prevents such a review; the practitioner would be required to review the 12-month history upon restoration of the CSRS after an outage. In addition, a practitioner would be able to, but not required to, review a patient's CSRS history if: 1) the controlled substance is to be administered to the patient in a hospital or other health care facility;

2) the controlled substance is for the treatment of cancer or a cancer-associated condition; 3) the controlled substance is prescribed to a patient in hospice care; or 4) the prescription is for five days or less and cannot be refilled, or is for seven days or less for relief of post-operative pain.

- 90-113.74C: would require a dispenser to review an individual's 12-month history in the CSRS whenever: 1) the dispenser believes the individual is seeking controlled substances for reasons other than treatment of a medical condition; 2) the prescriber is located outside of the usual area the dispenser serves; 3) the individual lives outside the usual area the dispenser serves; 4) the individual pays with cash when there is an insurance plan on file with the dispenser; or 5) the individual demonstrates potential misuse of a controlled substance. A dispenser would be required to withhold delivery of a prescription until verified if the dispenser believes it to be duplicative or fraudulent.
- 90-113.75A: would create a special revenue fund in DHHS for use in administering the CSRS.
- 90-113.75B: would require all boards which license individuals who can prescribe controlled substances to charge a $20 CSRS annual fee. The boards would be required to retain 10% of the fees collected and remit 90% to DHHS for the special revenue fund created in G.S. 90-113.75A.
- 90-113.75C: would require DHHS to make annual reports, starting November 1, 2018, to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy. The reports would be required to include the following information on Schedule II through Schedule V substances reported to the CSRS: 1) total prescriptions dispensed, broken down by Schedule; 2) demographics of ultimate users; 3) number of pills dispensed per prescription; 4) number of ultimate users who were prescribed a controlled substance by two or more practitioners; 5) number of ultimate users to whom a prescription was dispensed in more than one county; 6) the categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner; 7) prescribing behavior of practitioners that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior; and 8) any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy.

PART VI: APPROPRIATION FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES

Section 14 would appropriate 10 million dollars each for the 2017-2018 and the 2018-2019 fiscal year to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The funds would only be used for increasing the availability of community-based treatment and recovery services for substance use disorders, including medication-assisted treatment.

EFFECTIVE DATE: Sections 1, 2, 3, 4, 6, 8, and 14 would become effective July 1, 2017. Sections 5 and 7 would become effective July 1, 2018. The portion of Section 13 creating the new statutes G.S. 90-113.75A through G.S. 90-113.75C would become effective September 1, 2017. The remainder of the act would become effective when it becomes law and would apply to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the CSRS database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 175*

Short Title:	Strengthen Opioid Misuse Prevention (STOP)Act.	(Public)
Sponsors:	Senators J. Davis, McInnis, Rabon (Primary Sponsors); Britt, Brock, Chaudhuri, Clark, Cook, Dunn, B. Jackson, Krawiec, Lee, Lowe, Newton, Sanderson, Smith-Ingram, Van Duyn, and Woodard.	
Referred to:	Rules and Operations of the Senate	

March 6, 2017

A BILL TO BE ENTITLED

AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE SCHEDULE II THROUGH V CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF SCHEDULE II THROUGH V CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF SCHEDULE II THROUGH V CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS; MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; IMPOSING AN ANNUAL FEE ON PRACTITIONERS TO BE DEPOSITED INTO THE CSRS SPECIAL REVENUE FUND; REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS; AND APPROPRIATING FUNDS FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES.

The General Assembly of North Carolina enacts:

PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"§ 90-12.7. 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:

a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

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:

1. A family member, friend, or other person.

2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director or a designee may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(3) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the 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.

(c) A pharmacist may dispense an opioid antagonist to a person ~~described in subdivision (b)(1) of this section~~ or organization pursuant to a prescription issued ~~pursuant to~~ 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.

(c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section 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. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.

(d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) 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.

(e) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.

(3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.

(4) The State Health Director acting pursuant to subsection (b) of this section.

(5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a controlled substance included in Schedule II through V of Article 5 of Chapter 90 of the General Statutes and therapeutic use of the controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 4. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a controlled substance included in Schedule II through V of Article 5 of Chapter 90 of the General Statutes and therapeutic use of the controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a Schedule II through V controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-106 reads as rewritten:

"**§ 90-106. Prescriptions and labeling.**

(a) ~~Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner.~~ No Schedule II substance shall be dispensed pursuant to a written or electronic prescription more than six months after the date it was prescribed.

(a1) Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all controlled substances included in Schedule II through V of this Article. This subsection does not apply to prescriptions for Schedule II through V controlled substances issued by any of the following:

(1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.

(2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility as defined in G.S. 14-32.2.

(3) A practitioner who experiences temporary technological or electrical failure that prevents the prescription from being transmitted electronically; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(4) A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(a2) A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a controlled substance included in Schedule II through V of this Article. A dispenser may continue to dispense controlled substances included in Schedules II through V of this Article from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.

(a3) A practitioner may not prescribe more than a five-day supply of any controlled substance included in Schedule II through V of this Article upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for immediate post-operative pain relief. A practitioner may not prescribe more than a seven-day supply of any controlled substance included in Schedule II through V of this Article for immediate post-operative pain relief. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a Schedule II through V controlled substance.

(a4) As used in this subsection, the following terms have the following meanings:

(1) Acute pain. – Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

(2) Chronic pain. – Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(b) In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.

(c) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.

(d) No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.

(e) No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.

(f) No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.

(g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.

(h) A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

(i) A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 6. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.**

Any hospice or palliative care provider who prescribes a controlled substance included in Schedule II through V of this Article to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall make diligent efforts to ensure that any residual portion of the controlled substance is safely disposed of following the death of the patient. The hospice or palliative care provider shall comply with all applicable State and federal laws in carrying out the requirements of this section."

SECTION 7. Article 51 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-51-56. Limitation on co-payments for limited, initial opioid prescriptions.**

Every health benefit plan delivered or issued for delivery in this State that provides coverage for prescription drugs subject to co-payment shall charge a co-payment for a limited, initial prescription of a Schedule II through V controlled substance prescribed in accordance with G.S. 90-106(a3) in an amount that is (i) proportional between the co-payment charged for a 30-day supply of the controlled substance and the amount of the controlled substance prescribed to the beneficiary or (ii) equivalent to the co-payment for a 30-day supply of the controlled substance; provided, however, that the health benefit plan shall not subject the beneficiary to any additional co-payments for any additional prescriptions of the same controlled substance for the remainder of the 30-day supply."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

"(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No ~~public~~ State funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

SECTION 9. G.S. 90-113.72 reads as rewritten:

"**§ 90-113.72. Definitions.**

The following definitions apply in this Article:

(1) ~~"Commission" means the~~ Commission. – The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(2) ~~"Controlled substance" means a~~ Controlled Substance. – A controlled substance as defined in G.S. 90-87(5).

(3) ~~"Department" means the~~ Department. – The Department of Health and Human Services.

(4) ~~"Dispenser" means a~~ Dispenser. – A person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:

a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

b. Repealed by Session Laws 2013-152, s. 1, effective January 1, 2014, and applicable to prescriptions delivered on or after that date.
c. A wholesale distributor of a Schedule II through V controlled substance.
~~d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.~~

(4a) Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A.

(5) ~~"Ultimate user" means a~~ Ultimate user. – A person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the person's own use, for the use of a member of the person's household, or for the use of an animal owned or controlled by the person or by a member of the person's household."

SECTION 10. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting ~~system.~~system; civil penalties for failure to properly report.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than ~~the close of business three business days after the day when the prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than~~ 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.
(2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:
a. Full address, including city, state, and zip code,
b. Telephone number, and
c. Date of birth.
(3) The date the prescription was written.
(4) The date the prescription was filled.
(5) The prescription number.
(6) Whether the prescription is new or a refill.
(7) Metric quantity of the dispensed drug.
(8) Estimated days of supply of dispensed drug, if provided to the dispenser.
(9) National Drug Code of dispensed drug.
(10) Prescriber's DEA number.
(11) Method of payment for the prescription.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than two hundred fifty dollars ($250.00) for a first violation and five hundred dollars ($500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of ten thousand dollars ($10,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74(b1) reads as rewritten:

"(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:

...

(1a) Notify practitioners of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

...."

SECTION 12. G.S. 90-113.74(c) reads as rewritten:

"(c) The Department shall release data in the controlled substances reporting system to the following persons only:

...

(11) Any third-party payer or pharmacy benefits manager acting as agent of a third-party payer, for the purposes of (i) claimant case management, (ii) detection of inappropriate prescribing of a controlled substance to a claimant, or (iii) detection of misuse or diversion of a controlled substance by a claimant."

SECTION 13. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"**§ 90-113.74A. Mandatory dispenser registration for access to controlled substances reporting system.**

Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

"**§ 90-113.74B. Practitioner use of controlled substances reporting system; mandatory reporting of violations.**

(a) Prior to initially prescribing a Schedule II through V controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances

reporting system pertaining to the patient and the review shall be documented in the patient's medical record.

(b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a Schedule II through V controlled substance to the patient in any of the following circumstances:

(1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, or residential care facility as defined in G.S. 14-32.2.

(2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.

(3) The controlled substance is prescribed to a patient in hospice care or palliative care.

(4) The controlled substance is prescribed in an amount indicated for a period not to exceed five days and does not allow a refill, or for a period not to exceed seven days if the prescription indicates the controlled substance is for immediate post-operative pain relief.

(c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

"**§ 90-113.74C. Dispenser use of controlled substances reporting system.**

(a) Prior to dispensing a Schedule II through V controlled substance, a dispenser shall review the information in the controlled substances reporting system pertaining to the patient for the preceding 12-month period and document this review whenever:

(1) The dispenser has a reasonable belief that the ultimate user may be seeking a Schedule II through V controlled substance for any reason other than the treatment of the ultimate user's existing medical condition.

(2) The prescriber is located outside of the usual geographic area served by the dispenser.

(3) The ultimate user resides outside of the usual geographic area served by the dispenser.

(4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser.

(5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following:

a. Over-utilization of the controlled substance.

b. Requests for early refills.

c. Utilization of multiple prescribers.

d. An appearance of being overly sedated or intoxicated upon presenting a prescription.

e. A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks.

(b) If a dispenser has reason to believe a prescription for a Schedule II through V controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate. A dispenser shall be immune from any civil or criminal liability for actions authorized by this subsection.

"**§ 90-113.75A. Creation of Controlled Substances Reporting System Fund.**

(a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.

(b) The Fund shall consist of the following:

(1) Moneys transmitted to the Fund pursuant to G.S. 90-113.75B.

(2) Any moneys appropriated to the Fund by the General Assembly.

(3) Any moneys received from State, federal, private, or other sources for deposit into the Fund.

(c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"**§ 90-113.75B. Controlled substances reporting system fee.**

(a) Beginning January 1, 2018, each licensing board authorized to issue an initial or renewal license that confers upon the licensee the authority to prescribe a controlled substance for the purpose of providing medical care for a patient shall impose an annual controlled substances reporting system fee in the amount of twenty dollars ($20.00) on the licensee. This fee shall be in addition to any other initial or renewal license fee the licensing board is authorized to collect from the licensee under Chapter 90 of the General Statutes. The licensing board shall collect the fee required by this subsection at the same time it collects the initial or renewal license fee imposed on the licensee. Each licensing board shall retain ten percent (10%) of the total amount of moneys collected for the controlled substances reporting system fee pursuant to this subsection to cover the costs incurred by the licensing board for collecting and providing an accounting of all moneys received as payment of this fee. On the first day of each calendar quarter, each licensing board shall transmit ninety percent (90%) of the total amount of moneys collected pursuant to this subsection during the preceding calendar quarter to the Controlled Substances Reporting System Fund created in G.S. 90-113.75A.

(b) This section shall not be construed to apply to an individual licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.

"**§ 90-113.75C. Annual report to General Assembly and licensing boards.**

Annually on November 1, beginning November 1, 2018, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about Schedule II through V controlled substances reported to the system during the preceding calendar year:

(1) The total number of prescriptions dispensed, broken down by Schedule.

(2) Demographics about the ultimate users to whom prescriptions were dispensed.

(3) Statistics regarding the number of pills dispensed per prescription.

(4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.

(5) The number of ultimate users to whom a prescription was dispensed in more than one county.

(6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors and surgeons shall be treated as distinct categories of practitioners.

(7) Prescribing behavior of practitioners that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

(8) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

PART VI. APPROPRIATION FOR COMMUNITY-BASED SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICES

SECTION 14. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars ($10,000,000) for the 2017-2018 fiscal year and the sum of ten million dollars ($10,000,000) for the 2018-2019 fiscal year. These funds shall not be used for any purpose other than to increase the availability of community-based treatment and recovery services for substance use disorders, including medication-assisted treatment. These funds shall not supplant existing funds for community-based treatment and recovery services for substance use disorders.

PART VII. EFFECTIVE DATE

SECTION 15.(a) Sections 1, 2, 3, 4, 6, 8, and 14 of this act become effective July 1, 2017.

SECTION 15.(b) Sections 5 and 7 of this act become effective July 1, 2018.

SECTION 15.(c) G.S. 90-113.75A through G.S. 90-113.75C, as enacted by Section 13 of this act, become effective September 1, 2017.

SECTION 15.(d) The remainder of this act is effective when it becomes law and applies to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

North Carolina General Assembly
Senate Committee on Health Care

STATE OF NORTH CAROLINA
County of Wake

In the General Assembly of
North Carolina

SUBPOENA

TO: Secretary Mandy K. Cohen, MD, MPH
North Carolina Department of Health and Human Services
101 Blair Drive
Raleigh North Carolina 27603
919-855-4820

GREETING:

YOU ARE HEREBY COMMANDED to appear before the Senate Committee on Health Care (hereinafter "Committee") in Raleigh, North Carolina, on the 29th day of March, 2017, at 10:00 o'clock a.m., in Room 643 of the Legislative Office Building, 300 North Salisbury Street, Raleigh, North Carolina 27603, and as continued from time to time, to testify on matters before the Committee concerning your qualifications, potential conflicts of interest, and willingness to follow the law in your capacity as Secretary of the Department of Health and Human Services, as further detailed in the attached letter from the Committee Chairs, dated March 15, 2017.

This subpoena is issued upon authorization of:

_____
Senator Phil Berger
President Pro Tempore of the Senate

Issued this 15th day of March, 2017, by majority vote of the Committee:

_____
Senator Ralph Hise
Co-Chairman, Senate Committee on
Health Care
300 North Salisbury Street, Room 312
Raleigh, North Carolina 27603-5925

_____
Senator Joyce Krawiec
Co-Chairman, Senate Committee on
Health Care
300 North Salisbury Street, Room 308
Raleigh, North Carolina 27603-5925

_____
Senator Louis Pate
Co-Chairman, Senate Committee on
Health Care
300 North Salisbury Street, Room 311
Raleigh, North Carolina 27603-5925

OFFICER'S RETURN

I certify that the above subpoena was received on the _____ day of _____, 20_____, and that on the _____ day of _____, 20_____, it was served on _____ in the following manner:_____ _____.

_____

_____

G.S. 120-19.2; G.S. 1A-1, Rule 45

NORTH CAROLINA GENERAL ASSEMBLY

NORTH CAROLINA SENATE

March 15, 2017

VIA HAND DELIVERY

Secretary Mandy K. Cohen, MD, MPH
North Carolina Department of Health and Human Services
101 Blair Drive
Raleigh North Carolina 27603

Dear Dr. Cohen:

Congratulations on your nomination by Governor Cooper to serve as Secretary of the Department of Health and Human Services.

Your position is one that requires the advice and consent of the North Carolina Senate under N.C. Gen. Stat. § 143B-9 and Article III, Section 5(8) of the North Carolina Constitution. Additionally, because you were sworn in an acting capacity as Secretary of the Department, you are subject to the reporting and appearance obligations set out in Articles 5 and 5A of Chapter 120 of the General Statutes.

You have been asked to appear before the Senate Committee on Health Care on March 29, 2017, at 10:00 am. The point of the meeting is to allow the Committee to make an informed recommendation regarding your nomination. While we do not expect the meeting to be adversarial, you will be asked questions relating to your experience, potential conflicts of interest and your willingness to follow the law. While each member has discretion in selecting the questions he or she asks, we are providing to you a more detailed idea of what we expect will be potential areas of discussion.

To that end, enclosed is a rubric entitled "Potential Areas of Inquiry for Gubernatorial Nominees." You are not required to answer these questions prior to the meeting. However, we encourage you to give the potential questions thoughtful consideration and be prepared to discuss your answers with the committee's members. Of course, you are free to provide written responses, which may streamline or simplify the questions you receive during the meeting. Note

separately that the Committee will need a copy of your current Statement of Economic Interest prior to the hearing.

We look forward to seeing you on March 29, 2017. If you have further questions about the process, please do not hesitate to contact any of us.

Sincerely,

Senator Ralph Hise, Co-Chairman,
Senate Committee on Health Care

Senator Joyce Krawiec, Co-Chair
Senate Committee on Health Care

Senator Louis Pate, Co-Chairman,
Senate Committee on Health Care

cc: Gov. Roy Cooper

Enclosure

POTENTIAL AREAS OF INQUIRY FOR GUBERNATORIAL NOMINEES

**Unless specified otherwise, include responsive information for the past 15 years.*

QUALIFICATIONS

Education: Describe your undergraduate and graduate education history, including the institution(s), dates attended, degrees received and dates of degrees.

Honors and Awards: Detail all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and other special recognition you have received for outstanding service or achievement.

Employment History: Detail all positions held since college, including the title and description of each position, name of employer, location of work, and inclusive dates of employment.

Government Experience: Describe any experience in or direct association with federal, state, or local governments, including any advisory, consultative, board, honorary or other part time service or positions.

Membership, Affiliations and Activities: Detail all memberships and offices held in and services rendered to, professional, fraternal, business, scholarly, civic, charitable, political parties, election committees or other organizations. Include names of the organizations, as well as the office(s) and dates held.

Published Writings; Speeches: List/describe all books, articles, reports, seminar or other educational materials, editorials, speeches, prepared remarks or other published materials you have written, co-written or recorded, including those published only on the Internet. Please be prepared to provide a copy of documents that are not independently accessible. If copies are unavailable to you, list the title, publisher, date of publication, and a description of the published work. Include any videos that are responsive.

Teaching: Detail all courses you have taught. For each course, provide the title, the institution at which you taught the course, the years in which you taught the course, and describe briefly the subject matter of the course and the major topics taught.

POTENTIAL CONFLICTS OF INTERESTS

Employment Relationships, Outside Commitments During Service: Explain whether:

- You plan to sever all connections with your present employer, business firm, association or organization if you are confirmed by the Senate.
- As far as can be foreseen, you have any plans after completing this government service to resume employment, affiliation or practice with your previous employer, business firm, association or organization.
- Anyone has made you a commitment to a job after you leave government.
- You expect to serve the full term for which you have been appointed.
- You have any plans, commitments, or agreements to pursue outside employment, with or without compensation, during your service.

Impact of Prior Employment/Activities:

- Detail all previous job responsibilities for employers included in Section IV, "Employment History," that may stand in conflict to current or proposed rules, regulations, laws, or other policies of the state of North Carolina for which, if confirmed, you would be responsible for regulating.
- If you have engaged in any activities (including but not limited to consulting, advocacy, charitable, educational, electioneering, state or federal lobbying, goodwill lobbying, political, or otherwise) that relate, affect, or impact any of the areas that you would be responsible for regulating, if confirmed, provide all activities, time expended, and if financial or other benefits or compensation were received.
- Describe any business relationships, contracts, dealings or financial transactions (other than paying taxes) which you have had with the state of North Carolina, whether for yourself, on behalf of a client, or acting as an agent. Explain whether any of these relationships, dealings or transactions may, in any way, constitute or result in a possible conflict of interest with the position to which you have been nominated.
- For each area of potential or actual conflict identified, if any, detail how it will be remedied to fulfill your duty to faithfully discharge your duties of the office in which you have been nominated.

Political Contributions: List the political contributions over $50.00 that you have made to an individual, campaign organization, political party, political action committee or similar entity during the last 10 years and identify specific amounts, dates, and names of recipients.

Legal Actions:

- Provide the full details of any civil or criminal proceeding in which you were a defendant or any inquiry or investigation by a federal, state, or local agency in which you were the subject of the inquiry or investigation.
- Provide the full details of any proceeding, inquiry or investigation by any professional association, including any professional association in which you were the subject of the proceeding, inquiry or investigation.
- Have you or any business or organization of which you are or were an officer or board member, ever been involved as a party in interest in any administrative agency proceeding or civil litigation? If so, provide details.

VISITOR REGISTRATION SHEET

Health Care

(Committee Name)

3/15/17

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Grabowski	State Health Plan
Nique Williams	NCGA
Butch Gunnells	NC Bev
Evelyn Bostic	NC Medical Board
Thom Mansfield	NCMB
Cathy Burgess	CRNA
Stacy Yancey	NC Association of Nurse Anesthetists
Jennifer Mahaney	ASNC
Gene F. McNeil	STHL
Tony Adams	Adams and associates
W H Potter Jr	Sink & Potter NC Dental Soc
Robert Paschal	NC DOJ
Julia Adams-Schwartz	Oak City GR
Tracy Gallard	AHIC
Andy Chase	KMA
Christie Craig	WakeMed
Dawayne Nettles	Region D AAA
Julia White	Region A AAA

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Care Committee
(Committee Name)

March 15th, 2017
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patricia Singer MD	local MD
Charlene Edwards Green MD	American Anesthesiology
[illegible]	SA
[illegible]	CSS
Kari Barsness	Gateway Health
Crystal Feldman	SA
[illegible]	[illegible]
Tessie Castillo	NCHRC
Joe + Cathy Pieto	
[illegible]	CSS
Kara Weishaar	SA
Alex Asburn	DMH/DD/SAS
Maeu [illegible]	GSK
Mary Ellingboe	Local MD
Susan Vishneski MD	local MD
Connie Southard	NC Senior Tar Heel Legislature
Dorothy R. Crawford	" " "

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Care Committee

March 15th, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Robin Huffman	NC Psychiatric Assoc
CS Wells	CSI
Greg Grogan	NCAFP
Nathan Copeland	NCPA
Sarah McQuillan	RCNC
Ruien Mcnatt	UNM
Kathy Higgins	BP
AMES SIMMONS	EQUALITY NORTH CAROLINA
Carol Meyer	The Carolinas Center for Hospice
James Parker	Senior Torhcel Legislature
Grover Smith	Senior Tarheel Legislature
M.N. Grant	Piedmont Triad Anesthesia
Matt Hatch MD	North Carolina Society of Anesthesiologists
Dana Sipes	SA
Dodie Renfro	CCI2
Jon Blank MD	American Anesthesiology of N.C.

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Care Committee

March 15th, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Lexi Arthur	NCRMA
Andy Ellen	NCRMA
Elizabeth Robinson	NCRMA
Peyton Mayo	
Lania Hodack	UNC HCS
	Novant
Rob Hamm	TCEA
Brian Schwalm	BCBSNC.
Hudgins	NC Pediatric Society
Pep Heger	Care Mont
Emily Ziegler	UNC REX
Joel Maynard	GPM; NBSW
Brian Perkins	Alliance BHC
TJ Brybee	NP
Daniel VanLierre	Vidant Health
Daniel Bach	Truchman Simms
Steve Whitchell	AstraZeneca

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Care Committee

March 15th, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Bobby Lowery	NCBON
Donna B Clark	UNC
Elizabeth J Kranz RN BSN	Senior Tar Heel Legislature
Edward V Grimm	" " "
W. Gardner Pope	PPAB
KEVIN SPEIGHT	CONSTITUENT
Chris Livingston	MWC
Beacham Wray	citizen
BRIAN FLANAGAN	NC SENIOR TAR HEEL LEGISLATURE
Sheila Leach	NC Senior Tar Heel Legislature
Lisa Ward	NC Dental Society
Alec Parker	NC Dental Society
Caroline Miller	AMGA
JERRY SHELBY	NCSTHL
Eleanor Hairr	NC. STHL
Patricia Dutton	NC STHL
Glenda Dye	Mid-Carolina Area Agency on Aging

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Care Committee

March 15th, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Jessica Englert	Governor Cooper
Charles Jefferson	North Carolina Sevied Tar Heel Legislature
Gemma Shelby	The Policy Group
Jake Sipe	NCFPC
JOHN LUTZ	STHL
Chris McClure	PSS
SANDRA BUTLER TUBBS	STHL
Suja Jacob	Kerr Tar AHA
Jillian Hardin	Kerr Tar Area Agency on Aging
Amanda Donover	TJS
Michelle Frazier	SML
Steve Monge	NC DOJ
Fred Baggett	Police Chiefs Assn
Sarah Wolfe	MWC
Connie Wilson	NCOA
[illegible]	CSS
[illegible]	NCFPC
Jeri Bryant	NCFPC

09-21-201

VISITOR REGISTRATION SHEET

Senate Health Care Committee

March 15th, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	MHC

09-21-201

Senate Committee on Health Care
Thursday, March 29, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on March 29, 2017, in Room 643 of the Legislative Office Building. Eighteen members were present.

Senator Louis Pate, Chair, presided.

Senator Pate opened the meeting by recognizing the pages – Lauren Brown of Troy, Jack Hilbert of Fort Bragg, Henry Colella of Chapel Hill, Max Tweed of Raleigh, Nick Booth of Fairview, and Sebastian Turner of Charlotte; and the Sergeants-at-Arms – Terry Edmondson, John Enloe, Frances Patterson, and Terry Barnhardt.

He then explained that the purpose of the meeting was to consider the matter of the appointment of Dr. Mandy Cohen to the office of Secretary of the Department of Health and Human Services, and that a three-judge panel had recently affirmed the legislature's authority to hold these hearings. Senator Pate then explained how the meeting would be conducted, and that the intent was to vote on whether to recommend Dr. Cohen's confirmation to the Nominations Committee. He stated that the goal for committee members is to inform themselves as to whether Dr. Cohen is well-qualified for the office, whether she has any conflicts of interest and whether she intends to follow the law. Senator Pate stated that the chairs had received four letters of recommendation on behalf of Dr. Cohen, and ordered, without objection, that the letters be included in the committee record of the meeting.

Senator Pate then introduced Linda Garrett, court reporter from Worley Reporting, who transcribed the proceedings of the meeting. He explained the ground rules for the meeting, and then welcomed Dr. Cohen and invited her to stand for administering of the oath. After the oath was administered by court reporter Linda Garrett, Dr. Cohen made an opening statement.

Senators Harrington, Krawiec, Ballard, Hise, Tucker, Tarte, Woodard, D. Davis, Lowe, and Robinson asked the questions.

Dr. Cohen was asked if she had received a list of questions from the committee and if she had any written responses that she would like to give the committee. She was asked about her graduate and post-graduate work and degrees; scholarships, fellowships, honorary degrees, and awards; outside organizations where she has affiliations, memberships, or serves in a leadership role; published materials she has written, co-written, or recorded, including those published on the internet; and courses or classes she has taught. She was also asked about potential conflicts of interest – whether anyone had made a commitment for a job offer or other opportunity after she leaves government service, or whether she plans to pursue outside employment, paid or unpaid, with or without compensation during her service here as Secretary. She was asked if she had an

active medical license, and, if not at what point did it expire. She was asked to verify the date she was sworn in to become Secretary.

Dr. Cohen was asked if she agreed that attempting to expand Medicaid without legislative approval was a violation of state law, and whether she believed that the General Assembly would need to act prior to her or DHHS submitting a waiver to CMS to expand the Medicaid population. She was also asked whether she was contacted by anyone in North Carolina regarding Medicaid expansion or that particular waiver prior to accepting the position and coming to North Carolina or prior to being sworn in to the position.
She was questioned as to whether she agreed with the policy decision for LME/MCOs to be absorbed into prepaid health plans. She was also queried as to her role in the rollout of the Affordable Care Act website and her thoughts on child welfare, and asked for an update on mental health beds at Cherry and Broughton hospitals, as well as whether she planned to allow her board certification expire. She was questioned about her thoughts on a single payer system, and her experience with data security and her vision for data security for the department.

Dr. Cohen was asked, in light of her SEI disclosure statement, how she is prepared to take appropriate caution in her responsibilities. She was asked to elaborate on her time at the VA, internal audit reports with the VA, and women's health issues, as well as what she has learned from managing many different individuals, teams, processes, and organization; health care needs in rural communities; elder care; and strategies to address opioid and other substance abuse in communities.

Senator Krawiec moved that the Committee on Health Care recommend to the Committee on Nominations that Dr. Cohen be confirmed as Secretary of the Department of Health and Human Services; the motion carried unanimously.

The meeting adjourned at 11:10 AM.

Senator Louis Pate, Chair
Presiding

Susan Fanning, Committee Clerk

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	March 29, 2017	10:00 AM	643 LOB

Consider matter of recommendation on the confirmation of Mandy Cohen.

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

Senate Committee on Health Care
Wednesday, March 29, 2017 10:00 AM
643 Legislative Office Building

AGENDA

Senator Louis Pate, Presiding

Welcome and Opening Remarks

Introduction of Pages

The committee is meeting to consider the matter of recommendation on the confirmation of Dr. Mandy Cohen.

Adjournment

STATE ETHICS COMMISSION

1324 MAIL SERVICE CENTER
RALEIGH, NC 27699-1324
WWW.ETHICSCOMMISSION.NC.GOV

February 10, 2017

The Honorable Roy A. Cooper, III
Governor of North Carolina
20301 Mail Service Center
Raleigh, NC 27699-0301

Via Email

Re: Evaluation of Statement of Economic Interest Filed By Dr. Mandy K. Cohen
Secretary, Department of Health and Human Services

Dear Governor Cooper:

Our office is in receipt of **Dr. Mandy K. Cohen's** 2017 Statement of Economic Interest as Secretary of the **Department of Health and Human Services**. We have reviewed it for actual and potential conflicts of interest pursuant to Chapter 138A of the North Carolina General Statutes ("N.C.G.S."), also known as the State Government Ethics Act.

We did not find an actual conflict of interest, but found the potential for a conflict of interest. The potential conflict identified does not prohibit service on this entity.

The State Government Ethics Act establishes ethical standards for certain public servants, including conflict of interest standards. N.C.G.S. §138A-31 prohibits public servants from using their positions for their financial benefit or for the benefit of a member of their extended family or a business with which they are associated. N.C.G.S. §138A-36(a) prohibits public servants from participating in certain official actions from which the public servant, his or her client(s), a member of the public servant's extended family, or a business or non-profit with which the public servant or a member of the public servant's immediate family is associated may receive a reasonably foreseeable financial benefit.

Dr. Cohen will fill the role of Secretary. She was formerly employed by the U.S. Department of Health and Human Services in the Centers for Medicare and Medicaid Services. She disclosed that her spouse is Counsel in the law firm of Arent Fox LLP in the health care practice area. He primarily handles matters related to Federal health care policy. As such, she has the potential for a conflict of interest and should exercise appropriate caution in the performance of her public duties should issues regarding her husband's clients come before the Department for official action or otherwise seek to conduct business with the Department.

In addition to the conflicts standards noted above, N.C.G.S. §138A-32 prohibits public servants from accepting gifts, directly or indirectly (1) from anyone in return for being influenced in the discharge of their official responsibilities, (2) from a lobbyist or lobbyist principal, or (3) from a person or entity which is doing or seeking to do business with the public servant's agency, is regulated or controlled by the public servant's agency, or has particular financial interests that may be affected by the public servant's official actions. Exceptions to the gifts restrictions are set out in N.C.G.S. §138A-32(e).

Finally, the State Government Ethics Act mandates that all public servants attend an ethics and lobbying education presentation. Please review the attached document for additional information concerning this requirement.

Please contact our office if you have any questions concerning our evaluation or the ethical standards governing public servants under the State Government Ethics Act.

Sincerely,

Pamela B. Cashwell

Pamela B. Cashwell
Assistant Director

cc: Dr. Mandy K. Cohen

Attachment: Ethics Education Flyer

	NORTH CAROLINA STATE ETHICS COMMISSION **SUPPLEMENT TO THE 2017 STATEMENT OF ECONOMIC INTEREST**	For Office Use Only 2017 FEB -2 PM 12:19

Name of Person Filing Supplement: Mandy Cohen

Name of Agency or Board: Dept Health & Human Services

Date: 1/30/17

17. Are you an appointee or prospective appointee to:	
a. the head of a principal state department (e.g. cabinet secretary) appointed by the Governor; or b. a North Carolina Supreme Court Justice, Court of Appeals, Superior or District Court Judge; or c. a member of any of the following boards: • ABC Commission • Coastal Resources Commission • State Board of Education • State Board of Elections • Division of Employment Security • Environmental Management Commission • Industrial Commission • Human Resources Commission • Rules Review Commission • Board of Transportation • UNC Board of Governors • Utilities Commission • Wildlife Resources Commission	☒ **Yes** ☐ **No** **If "No", proceed to question 18.**
d. If so, were you appointed or are you being considered for appointment to that public position by a Council of State member? Council of State members are listed in question 16.	☒ **Yes** ☐ **No** **If "No", proceed to question 18.**
e. If so, you must indicate whether during 2015 you (not immediate family members) engaged in any of the following activities with respect to or on behalf of the candidate or campaign committee of the Council of State member who appointed you to your public position: i. Collected contributions from multiple contributors, took possession of such multiple contributions, and transferred or delivered those collected contributions to the candidate or committee? Contributions are defined in question 16.	☐ **Yes** ☒ **No**
ii. Hosted a fundraiser at your residence or place of business?	☐ **Yes** ☒ **No**
iii. Volunteered for campaign-related activities, which include, but are not limited to, phone banks, event assistance, mailings, canvassing, surveying, or any other activity that advances the campaign of a candidate?	☐ **Yes** ☒ **No**

This entire document and any attachments are public record.

AFFIRMATION

I affirm that the information provided in this Statement of Economic Interest and any attachments hereto are true, complete, and accurate to the best of my knowledge and belief.

I also certify that I have not transferred, and will not transfer, any asset, interest, or property for the purpose of concealing it from disclosure while retaining an equitable interest.

I understand that my Statement of Economic Interest and any attachments or supplements thereto (with the exception of the Confidential Form regarding Unemancipated Children) are public record.

I acknowledge that I have read and understand N.C.G.S. 138A-26 regarding concealing or failing to disclose material information and N.C.G.S. 138A-27 regarding providing false information:

> § 138A-26. Concealing or failing to disclose material information.
>
> A filing person who knowingly conceals or knowingly fails to disclose information that is required to be disclosed on a statement of economic interest under this Article shall be guilty of a Class 1 misdemeanor and shall be subject to disciplinary action under G.S. 138A-45.
>
> § 138A-27. Penalty for false information.
>
> A filing person who provides false information on a statement of economic interest as required under this Article knowing that the information is false is guilty of a Class H felony and shall be subject to disciplinary action under G.S. 138A-45.

☒ **I Agree**

Mandy Krautheimer Cohen
Printed Name

MK Cohen
Signature

1/31/17
Date

Submit SIGNED, ORIGINAL documents only.

Do not fax or email this form.

This entire document and any attachments are public record.

NORTH CAROLINA STATE ETHICS COMMISSION

2017 STATEMENT OF ECONOMIC INTEREST

919-814-3600 www.ethicscommission.nc.gov

COMPLETE THIS FORM AND MAIL SIGNED, ORIGINAL TO
STATE ETHICS COMMISSION, 1324 MAIL SERVICE CENTER, RALEIGH, NC 27699-1324

FILER'S NAME (FIRST, MIDDLE, LAST)				
Prefix	**First Name**	**Middle Name**	**Last Name**	**Suffix**
Dr.	Mandy	Krauthamer	Cohen	

CURRENT EMPLOYER	JOB TITLE
NC Dept of Health and Human Services	Secretary

NATURE OR TYPE OF BUSINESS
Health

REASON FOR FILING (SELECT ALL THAT APPLY)	
STATE GOVERNMENT JOB (Specify Agency)	BOARD/COMMISSION (List complete name of all State boards on which you are serving or are being considered)
Health and Human Services, Department of	
JUDICIAL OFFICER (Specify Office)	LEGISLATOR (Specify House or Senate)

A. Do other immediate family members reside in your household?

☑ Yes ☐ No

When used throughout this form, the term **Immediate family** includes your spouse (unless legally separated). It also includes members of your extended family (your and your spouse's children, grandchildren, parents, grandparents, and siblings, and the spouses of each of those persons) **who reside in your household.**

List the full name of **all adults** and **emancipated minors** in your household. A minor is a child under 18 years old. Minors are emancipated by marriage, enlistment in the US military, or court order for emancipation.

FULL NAME OF ADULTS & EMANCIPATED MINORS	RELATIONSHIP	EMPLOYER	JOB TITLE	NATURE OF BUSINESS
Samuel Charles Cohen	husband	Arent Fox LLP	Of Councel	federal health care regulatory

B. List **ONLY the initials** of all **unemancipated minors** in your household below. A minor is a child under 18 years old.

Note: You must list the full name of each minor child on the Confidential Form available at the end of this document.

INITIALS FOR UNEMANCIPATED CHILDREN	RELATIONSHIP	EMPLOYER	JOB TITLE	NATURE OF BUSINESS
SRC	daughter	n/a	n/a	n/a
EMC	daughter	n/a	n/a	n/a

PROPERTY INTERESTS

1. As of December 31, 2016, did you, your spouse, or members of your immediate family:

A. Have an ownership interest in North Carolina real estate (including your residence) with a market value of $10,000 or more?

☐ Yes ☑ No

Owner of Real Estate	% Ownership Interest	Location by City	Location by County

B. Lease or rent real estate or personal property to or from the State of North Carolina with a market value of $10,000 or more?

☐ Yes ☑ No

Name of Lessor	Name of Lessee (Renter)	If Real Estate, Location by City & County	If Personal Property, Describe

2. At any time during 2015 or 2016 , did you, your spouse, or members of your immediate family sell to or buy from the State of North Carolina personal property with a market value of $10,000 or more?

☐ Yes ☑ No

Name of Purchaser	Name of Seller	Type of Property

FINANCIAL INTERESTS

3. As of December 31, 2016, did you, your spouse, or members of your immediate family own any of the following financial interests valued at $10,000 or more? LIST EACH COMPANY INDIVIDUALLY

A. Stock in a publicly owned company?

☐ Yes ☑ No

- Do not list ownership interests in a widely held investment fund (including mutual funds, regulated investment companies, or pension or deferred compensation plans) if: (i) the fund is publicly traded or its assets are widely diversified; and (ii) neither you nor an immediate family member are able to control the assets held in the mutual fund, investment company, or pension or deferred compensation plan.

Owner of Interest	Full Name of Company (Do not use a ticker symbol)

B. Stock Options in a company or business?

☐ Yes ☑ No

Owner of Stock Option	Full Name of Company (Do not use a ticker symbol)

C. Interests in a non-publicly owned company or business entity (including interests in sole proprietorships, partnerships, limited partnerships, joint ventures, limited liability companies, limited liability partnerships, and closely held corporations)?

☐ Yes ☑ No **If "No", proceed to question 4.**

Owner of Interest	Name of Company or Business Entity

C (1). For each non-publicly owned company or business entity (the "primary company") identified in question 3.C above, please list the names of *any other companies or business entities* in which the primary company owns securities or equity interests valued at over $10,000, *if known*.

Non-Publicly Owned Company or Business Entity (the Primary Company)	Other Companies in which the Primary Company Owns Security or Equity Interests
☐ None or Not Known	

C (2). If you know that any company or business entity listed in 3.C or 3.C(1) above has any material business dealings or business contracts *with the State of North Carolina*, or is *regulated by the State*, provide a brief description of that business activity.

Name of Company or Business Entity	Description of Business Activity with the State
☐ None or Not Known	

4. As of December 31, 2016, were you, your spouse, or members of your immediate family the beneficiaries of a vested trust with a value of $10,000 or more that was created, established, or controlled by you?
Do not list assets held in blind trusts. See 2017 SEI Helpful Tips for the definition of "Vested Trust" and "Blind Trust."
☐ Yes ☑ No

Name and Address of Trustee	Description of the Trust	Your Relationship to the Trust

5. As of December 31, 2016, did you, your spouse, or members of your immediate family have liabilities of $10,000 or more, excluding the mortgage on your primary personal residence? Examples include credit card debts, auto loans, student loans, personal loans and intra-family debt.
☑ Yes ☐ No

Name of Debtor (You, Spouse, Immediate Family Member)	Type of Creditor (Commercial Bank, Credit Union, Individual, etc.)
Mandy Cohen	individual student loans
Sam Cohen	individual student loans

6. List each source of income (not specific amounts) of more than $5,000 received by you, your spouse, or members of your immediate family during 2016. Include salary, wages, state/local government retirement, professional fees, honoraria, interest, dividends, rental income, business income, and other types of income required to be reported on your State and federal tax returns.

Do not include income received from the following sources:

- **Capital gains**
- **Federal government retirement**
- **Military retirement**
- **Social security income/SSDI**

Recipient of Income	Name of Source	Type of Business/Industry	Type of Income
☐ I had no reportable income over $5,000 in 2016.			
Mandy Cohen	US Dept HHS	Centers for Medicare and Medicaid Services	salary
Samuel Cohen	Arent Fox LLP	law firm	salary

PROFESSIONAL AND CIVIC RELATIONSHIPS

7(a). During 2016, were you, your spouse or members of your immediate family a director, officer, governing board member, employee, independent contractor, or registered lobbyist of a nonprofit corporation or organization operating in the State of North Carolina primarily for religious, charitable, scientific, literary, public health and safety, or educational purposes?

☐ Yes ☑ No **If "No", proceed to question 8.**

- Do not list State boards or entities, or entities created by a political subdivision of the State.
- Do not list organizations of which you are a mere member.

Name of Person	His/Her Position	Name of Nonprofit Corporation or Organization	Nature of Business or Purpose of Organization

7(b). If the nonprofit corporations or organizations listed above do business with the State of North Carolina or receive State funds, please provide a brief description of the nature of that business, if known or with which due diligence could reasonably be known.

Name of Nonprofit Corporation or Organization	Describe State Business or State Funding
☐ None or Not Known	

Please answer the following question as it pertains to the following board/agency:

Health and Human Services, Department of

8. During 2016, were you, your spouse, or members of your immediate family a director, officer, or governing board member of any society, organization, or advocacy group with an interest in matters over which your agency or board may have jurisdiction?

☐ Yes ☑ No ☐ Legislator/Judicial Officer - You are not required to complete this question if you are filing because you are a legislator or a judicial officer or you are filing as an appointee to those offices.

▸ Do not list organizations of which you are only a member (not serving in a leadership role).

Name of Person	Name of Society, Organization or Advocacy Group	Leadership Position (Director, Officer, Board Member)

9(a). List the name of each company or business with which you were associated where you or a member of your immediate family was an employee, director, officer, partner, proprietor, or member or manager as of December 31, 2016.

Name of Person	Relationship to Filer	Name of Company	Role of Person
☐ No Business Associations			
Sam Cohen	husband	Arent Fox	associate attorney

9(b). If you know that any company or business entity listed in 9(a) above had any material business dealings or business contracts with the State of North Carolina or was regulated by the State as of December 31, 2016, provide a brief description of that business activity.

Name of Company or Business Entity	Description of Business Activity with the State
☐ Not applicable (No entities listed on #9a) ☑ No relationship / Not known	

10. Are you a practicing attorney?

☐ Yes ☑ No ☐ Judicial Officer/State Attorney

If "Yes", check each category of legal representation in which you or the law firm with which you are affiliated has earned legal fees of more than $10,000 during 2016.

☐ Administrative	☐ Admiralty	☐ Corporate	☐ Criminal
☐ Decedent's Estates	☐ Environmental	☐ Insurance	☐ Labor
☐ Local Government	☐ Real Property	☐ Securities	☐ Tax
☐ Tort litigation (including negligence)	☐ Utilities Regulation	☐ Other category not listed.	

11. During 2016, were you a licensed professional (other than an attorney) or did you provide consulting services individually or as a member of a professional association for which you charged or were paid over $10,000?

☐ Yes ☑ No

Type of Business	Nature of Services Rendered

Please answer the following question as it pertains to the following board/agency:

Health and Human Services, Department of

12. Are you or your employer, your spouse or members of your immediate family, or their employer currently:

- Licensed by the State board or employing entity with which you are or will be associated **or**
- Regulated by the State board or employing entity with which you are or will be associated **or**
- Have a business relationship with the State board or employing entity with which you are or will be associated?

☐ Yes ☑ No ☐ Legislator/Judicial Officer - You are not required to complete this question if you are filing because you are a legislator or a judicial officer ("judicial officer" is defined in the SEI Helpful Tips) or you are filing as an appointee to those offices.

Name of Person	Name of Employer (if applicable)	Type of Relationship (Licensing, Regulatory, Business)

13. Are you, your spouse, or a member of your immediate family currently registered as a lobbyist or lobbyist principal or were you registered as such within the 12 months preceding your filing of this form?

☐ Yes ☑ No

Name of Lobbyist	Lobbyist's Principal	Date of Registration	Registration Expiration

OTHER DISCLOSURES

14. During any calendar quarter in 2016 (but only the time period after you were appointed, employed or filed or were nominated as a candidate), did you

• receive any gift(s) exceeding $200 per quarter from a person or group of persons acting together, **and**

• when both you and those person(s) were outside North Carolina at the time you accepted the gift(s), **and**

• the gift(s) were given under circumstances that would lead a reasonable person to conclude that they were given for lobbying?

☐ Yes ☑ No

- Do not report gifts given by members of your extended family.
- Do not report gifts that have previously been reported by you to the Department of the Secretary of State on the "Expense Report for Exempted Persons."

Date Item Received	Name and Address of Donor(s)	Describe Item Received	Estimated Market Value

Please answer the following question as it pertains to the following board/agency:

Health and Human Services, Department of

15. During 2016 (but only the time period after you were appointed, employed, or filed or were nominated as a candidate) did you

• accepted a "scholarship" exceeding $200 from a person or group of persons acting together **and**

• those person(s) were outside North Carolina **and**

• the scholarship was related to your public position? **A "scholarship" is a grant-in-aid, either direct or indirect, to attend a conference, meeting, or similar event, including tuition, travel, lodging, meals, and other similar expenses.**

☐ Yes ☑ No ☐ Judicial Officer - You are not required to complete this question if you are a judicial officer or you are filing as a judicial officer appointee.

- Do not report gifts that have previously been reported by you to the Department of the Secretary of State on the "Expense Report for Exempted Persons."
- Legislators are not required to report scholarships paid by a nonpartisan legislative organization of which the legislator or the General Assembly is a member or participant or an affiliate of that organization.

Date of Scholarship	Name and Address of Donor(s)	Describe Event	Estimated Market Value

Please answer the following question as it pertains to the following board/agency:

Health and Human Services, Department of

16. Were you appointed or are you being considered for an appointment to a covered board by the **Governor** or another Council of State member?

Council of State members are:

- Governor
- Lt. Governor
- Secretary of State
- State Auditor
- State Treasurer
- Superintendent of Public Instruction
- Attorney General
- Commissioner of Agriculture
- Commissioner of Labor
- Commissioner of Insurance

☐ Yes ☑ No

If "Yes", list all contributions you (NOT immediate family members) made during 2016 with a cumulative total of more than $1,000 to the Governor or other Council of State member who appointed you.

- Contributions are defined in N.C.G.S. 163-278.6(6) and include, but are not limited to, "any advance, conveyance, deposit, distribution, transfer of funds, loan, payment, gift, pledge or subscription of money or anything of value whatsoever."

Date	Amount	Contributed to
☐ No contribution(s) with a cumulative total of more than $1,000		

Please answer the following question as it pertains to the following board/agency:

Health and Human Services, Department of

17. Are you an appointee or prospective appointee to:

a. the head of a principal state department (e.g. cabinet secretary) appointed by the Governor; or b. a North Carolina Supreme Court Justice, Court of Appeals, Superior or District Court Judge; or c. a member of any of the following boards: • ABC Commission • Coastal Resources Commission • State Board of Education • State Board of Elections • Division of Employment Security • Environmental Management Commission • Industrial Commission • Human Resources Commission • Rules Review Commission • Board of Transportation • UNC Board of Governors • Utilities Commission • Wildlife Resources Commission	☑ Yes ☐ No **If "No", proceed to question 18.**
d. If so, were you appointed or are you being considered for appointment to that public position by a Council of State member? Council of State members are listed in question 16.	☐ Yes ☑ No **If "No", proceed to question 18.**
e. If so, you must indicate whether during 2016 you (not immediate family members) engaged in any of the following activities with respect to or on behalf of the candidate or campaign committee of the Council of State member who appointed you to your public position: i. Collected contributions from multiple contributors, took possession of such multiple contributions, and transferred or delivered those collected contributions to the candidate or committee? Contributions are defined in question 16.	☐ Yes ☐ No
ii. Hosted a fundraiser at your residence or place of business?	☐ Yes ☐ No
iii. Volunteered for campaign-related activities, which include, but are not limited to, phone banks, event assistance, mailings, canvassing, surveying, or any other activity that advances the campaign of a candidate?	☐ Yes ☐ No

18. Have you ever been convicted of a felony for which you have not received either: (i) a pardon of innocence; or (ii) an order of expungement regarding that conviction?

☐ Yes ☑ No

Offense	Date of Conviction	County of Conviction	State of Conviction

19. Are you aware of any other information that *you believe* may assist the State Ethics Commission in advising you concerning your compliance with the State Government Ethics Act?

☐ Yes ☑ No If yes, please provide such information below.

AFFIRMATION

I affirm that the information provided in this Statement of Economic Interest and any attachments hereto are true, complete, and accurate to the best of my knowledge and belief.

I also certify that I have not transferred, and will not transfer, any asset, interest, or property for the purpose of concealing it from disclosure while retaining an equitable interest.

I understand that my Statement of Economic Interest and any attachments or supplements thereto (with the exception of the Confidential Form regarding Unemancipated Children) are public record.

I acknowledge that I have read and understand N.C.G.S. 138A-26 regarding concealing or failing to disclose material information and N.C.G.S. 138A-27 regarding providing false information:

§ 138A-26. Concealing or failing to disclose material information.

A filing person who knowingly conceals or knowingly fails to disclose information that is required to be disclosed on a statement of economic interest under this Article shall be guilty of a Class 1 misdemeanor and shall be subject to disciplinary action under G.S. 138A-45.

§ 138A-27. Penalty for false information.

A filing person who provides false information on a statement of economic interest as required under this Article knowing that the information is false is guilty of a Class H felony and shall be subject to disciplinary action under G.S. 138A-45.

☑ I Agree. It is my intention that this check box constitutes my electronic signature. By checking this box I certify that the information provided in this Statement of Economic Interest and any attachments hereto are true, complete, and accurate to the best of my knowledge and belief.

Filed Electronically — Signature

1/31/2017 — Date

Mandy Krauthamer Cohen — Printed Name

UNC HEALTH CARE

WILLIAM L. ROPER, MD, MPH
CEO, UNC HEALTH CARE SYSTEM

roper@med.unc.edu
O 919-966-4161 | C 919-966-8623

UNC HEALTH CARE SYSTEM
4030 Bondurant Hall | Campus Box 7000
Chapel Hill, NC 27599-7000
unchealthcare.org

March 27, 2017

The Honorable Ralph Hise
300 N. Salisbury Street
Legislative Office Building, Room 312
Raleigh, NC 27603-5925

Dear Senator Hise:

I am writing today to offer my strong recommendation that the Senate confirm Dr. Mandy Cohen as the Secretary for the North Carolina Department of Health and Human Services.

Over the last several months it has been my honor to spend time with Dr. Cohen as we discussed a number of policies that affect the health care community across our state. From our initial introduction, and as our working relationship has progressed, I continue to be deeply impressed by her leadership, intellect and ability to serve all North Carolinians. As you are aware, I served under President Ronald Reagan as the Director of the Health Care Financing Administration. This was the precursor to the Centers for Medicare and Medicaid Services, where Dr. Cohen has most recently served. I know the skill set and deep knowledge she gained while serving in this agency. This unique and well-honed expertise will be a tremendous asset to our state.

The responsibilities that fall under the North Carolina Department of Health and Human Services are extremely important to our fellow North Carolinians: Medicaid, Mental Health, Public Health, Children's Services and more. In short, with so many important and varied priorities, it is vital that we have a strong and effective leader who can manage these many facets of the Department of Health and Human Services. I believe Cohen is that person. She has the programmatic knowledge and personal commitment to serve our state and fellow citizens very well.

It is my earnest hope that you and she will forge a positive and beneficial partnership for the good of our State and its people.

Thank you very much for your service to our citizens and consideration of my letter of recommendation.

Sincerely,

William L. Roper, MD, MPH

cc: Senator Phil Berger
Senator Joyce Krawiec
Senator Louis Pate

North Carolina Medical Society

NCHA

NCHCFA
North Carolina Health Care Facilities Association

The Honorable Ralph Hise
The Honorable Joyce Krawiec
The Honorable Louis Pate
Senate Health Care Committee
643 Legislative Office Building
Raleigh, NC 27601

Dear Senators Hise, Krawiec, and Pate:

On behalf of the organizations representing North Carolina's physicians and physician assistants, hospitals and health systems, and skilled nursing facilities we are writing jointly to express our support for Dr. Mandy Cohen as our state's Secretary of Health and Human Services.

Dr. Cohen is eminently qualified to serve in this role. Not only does she bring her knowledge and insight as a physician to the job, she has extensive experience working effectively in a large and complex government agency to improve health care access and foster the innovations needed to contain costs while ensuring quality and value of care.

In our meetings thus far with Dr. Cohen, she has impressed us as a good listener with a deep understanding of the health policy issues affecting our members. Her background suggests she knows how to build strong partnerships to lead diverse groups to consensus. It also is apparent she is a hard worker.

We are particularly fortunate that Dr. Cohen also brings her knowledge of and experience with the federal Centers for Medicare and Medicaid Services (CMS) where she served as CMS Chief Operating Officer and Chief of Staff to the Administrator for CMS. Dr. Cohen's experience will be invaluable as North Carolina progresses to reform its Medicaid system in the coming months and years. She also brings a wealth of understanding about how to successfully manage health care technology platforms.

Dr. Cohen's record of accomplishment needs no embellishment. An undergraduate degree from Cornell University in policy analysis and management; an MD from Yale University and a Master of Public Health from Harvard University. Her education, her professional experience in developing and implementing health policy and her well-honed people skills all recommend her as an exemplary Secretary for the North Carolina Department of Health and Human Services.

Sincerely,

Robert W. Seligson, CEO, North Carolina Medical Society

Hugh Tilson, Interim President, North Carolina Hospital Association

J. Craig Souza, CEO, North Carolina Health Care Facilities Association

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

March 24, 2017

The Honorable Ralph Hise
The Honorable Joyce Krawiec
The Honorable Louis Pate
Senate Health Care Committee
643 Legislative Office Building
Raleigh, NC 27601

Dear Senators Hise, Krawiec, and Pate:

On behalf of the American Medical Association (AMA), I am writing to express the AMA's support for the nomination of Mandy Cohen, MD, MPH, to serve as Secretary of North Carolina's Department of Health and Human Services (DHHS). In multiple roles at the Centers for Medicare & Medicaid Services (CMS), Dr. Cohen played a key role in advancing initiatives to improve health care delivery and remove barriers to innovation. She has a strong track record of building productive relationships with physicians, other providers, and patient groups to enhance stakeholder engagement in shared efforts to maximize the return on government expenditures. Dr. Cohen consistently worked with and listened to the concerns of the physician community, striving to cut through bureaucracy and promote policies that enable physicians to spend more time with their patients.

Dr. Cohen possesses a wealth of knowledge about healthcare and health policy, including both Medicare and Medicaid. She also has substantial experience in overseeing large healthcare systems and managing complicated technology platforms, as demonstrated by her work within several federal agencies. During that time, Dr. Cohen also demonstrated her ability to balance the responsibilities of serving as both the CMS Chief Operating Officer and Chief of Staff to the Administrator for CMS.

In what might have been a tremendous disruption to both physician workflow and patient care, Dr. Cohen was instrumental in ensuring a smooth transition from ICD-9 to ICD-10 (by way of reference, the United States has approximately 155,000 ICD-10-CM and ICD-10-PCS codes compared to 18,000 ICD-9-CM codes). Further, Dr. Cohen worked extensively with the AMA and practicing physicians to implement the Medicare Access and CHIP Reauthorization Act, which is the first overhaul of Medicare physician payment in 25 years.

For the above reasons, we believe that the citizens of North Carolina will benefit from the knowledge, expertise, and leadership Dr. Cohen offers in the role as Secretary of DHHS.

Sincerely,

James L. Madara, MD

March 28th 2017

Senator Ralph Hise, Senator Joyce Krawiec, Senator Louis Pate, CoChairs
Senate Health Care Committee
643 Legislative Office Building
Raleigh, North Carolina 27601

Dear Senators Hise, Krawiec and Pate:

Thank you for your many contributions to North Carolina by serving in the Senate of our State's General Assembly.

We are grateful for the opportunity to comment on the upcoming consideration of Dr. Mandy Cohen's confirmation for Secretary of the North Carolina Department of Health and Human Services.

With Dr. Cohen being new to North Carolina we were eager to get to know her and hear about her vision for DHHS. In her few months here Dr. Cohen has already been engaged with the health and human services community having met with over 60 leaders from the health, children's, social services and related nonprofit sectors. In addition, she has met with key leaders in the medial field including association leaders, local health directors, and hospital leaders. In these meetings she has proven to be knowledgeable, professional, and has asked insightful questions that illustrate her commitment to best serve North Carolinians.

It is our goal to work effectively with legislative and executive leaders to figure out the best solutions to the complex problems facing the populations we serve. We share your interest in having a qualified Secretary to lead DHHS. Our experience with Dr. Cohen leads us believe she is someone who is ready to work productively with all of us to provide better services in North Carolina. She brings a knowledge and expertise that is valuable and an open responsive approach that is essential.

Thank you for this opportunity to provide these comments to you as you consider Dr. Cohen's confirmation. Given, her personal and professional attributes, we are very supportive of Dr. Mandy Cohen as Secretary of the Department of Health and Human Services.

Sincerely,

The Undersigned

CC: Senate Health Care Committee: Sen. Deanna Ballard, Sen. Dan Bishop, Sen. David Curtis, Sen. Don Davis, Sen. Jim Davis, Sen. Chuck Edwards, Sen. Valerie Foushee, Sen. Kathy Harrington, Sen. Rick Horner, Sen. Paul Lowe, Jr., Sen. Paul Newton, Sen. Gladys Robinson, Sen. Jeff Tarte, Sen. Tommy Tucker, Sen. Terry Van Duyn, Sen. Andy Wells, Sen. Mike Woodard

American Cancer Society Cancer Action Network
Disability Rights NC
Goldsboro Pediatrics
Independent Living Resources, Inc
Kate B. Reynolds Foundation
NC AIDS Action Network
NC Association of Child Advocacy Centers
NC Association of Local Health Directors
NC Association of Social Workers
NC Community Health Center Association
NC Early Education Coalition
NC Foundation for Leadership and Innovation
NC Institute for Child Development
NC Prevention Partners
Reach Out and Read
SaySo, Inc
UNC Gillings School of Global Public Health

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Thomas Blount, MD	NC Peds Society
ALAN DELLAPENNA	CFTF
Corey Griggs	NCAFP
Elizabeth Hudgins	NCPeds
Colleen Huseboe	NCPeds
Kathryn Carroll	NCPeds
Rebecca Forbes	NC Women for Cannabis
Kathleen Clarke-Pearson MD	NC Pediatric Society
Mark Eggell	APNC
Danny Lineberry	DIT
CS/Hills	CSG
Thom Mansfield	NCMB
Evelyn Contre	NCMB
Ken Wright	NC DOR
Scott Lassen	KCANC
Betsy McCorkle	KCANC
Sarah McQuillan	KCANC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Michelle Frazier	SML
Josh Lanier	SML
Chris Fitzsimon	NC Policy Watch
JOSHUA ALEXANDER, MD	NC PEDIATRIC SOCIETY
Laura Caligiuri, MD	NC Pediatric Society
Juliana Didi, MD	NC Pediatric Society
Kristen Monyan-Blanchard, MD	NC Pediatric Society
Anna Ruderman, MD	NC Pediatric Society
Avital Fischer, MD	NC Pediatric Society
Lynette Solano	NCALHD
Nique Wilson	NCEA
Sue Ann Forrest	NCMS
Matthew Babcock	PPAB
Becky Swipkin	NC Peds Society
Christoph Diasio, MD	Sandhills Pediatrics
Erin Sukhra MD	NC Peds Society
Sara Sanders, MD	NC Peds Society

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

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John Harrelson	MFS
John McMullen	
Will Morgan	MFS
Susan Murray	Blue Cross Blue Shield NC
Cary Pickett	BCBS NC
Mark Fleming	BCBSNC
Brad Adcock	Gaston
Kelly Vogel	PLPCC
Mike Adams	ACP
Sarah Stasny	NP
Martha M McConnell	Carolinas Healthcare System
TJ Bugbee	NP
Ryan Blankenship	Cone Health
Brian Perkins	Alliance BHC
Rick Zechini	Williams Mullen
Sherice Voducka	NC Alliance of YMCAs
JOE LANIER	TSS

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VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

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Allison Mathews	UNC Chapel Hill
Carl Pickney	DOT - Information Technology
Gabrielle Morsoff	UNC Healthcare
NATHAN COPELAND	NORTH CAROLINA HOSPITALASSN
Sharon Peters	CTS
Dodie Benfer	CCR
Amanda Dorner	CTS
Maggie Sauer	Edtn. for Health Leadership Innov.
STEPHANIE TYSON	RESOURCEFUL SOLUTIONS 3707 Latrobe Dr #450 28211
William EDWARDS	P.O. Box 913 THE EDWARDS GROUP SNOW HILL, NC 28580
DANIEL VANLEENE	V. ORAL HEALTH
DOUG HERON	2015 National Champions
Anastasia Beaverhousen	W & G
Andy Munn	Munn
Chris McClure	BSP
Mindy Peal	WellCare

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VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
	CSS
Rob Lamm	RLA
Daniel Blum	Troutman Sanders
Clay Bayst~~A~~	NCMS
Bethany Beasley, MD MPH	NCMS / Kernodle OBGYN
Ryan Menard	WM
Mark Hill	PSG
Dave Horne	SA
Leah Devlin	UNC Gillings School of Public Health
	None
Adam Sholar	NCHCFA
	~~as~~
	VSTA
	UNI REP
Kawa Kein	V-tw
Ciara Fahey	NC Justice Center
Luis Toledo	~~Bafl~~ Taxpayers

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Michele Rivest	NC. Early Education Coalition
Matt Gross	NC Child
Jamaica Pfister	Childrens Home Society
NICATOLE KARLIN	NAMI NC
Kay Castillo	NASW-NC
Mary Bethea	NC Coalition on Aging
Dick Carlton	Law Office of RHC PLLC

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VISITOR REGISTRATION SHEET

Senate Committee on Health Care

March 29, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Peyton Maynard	

09-21-201

Senate Committee on Health Care
Wednesday, April 05, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 05, 2017, in Room 643 of the Legislative Office Building. Eighteen Senate members were present.

Senator Joyce Krawiec presided.

Senator Krawiec opened the meeting by welcoming everyone and recognizing the Senate Sergeants-at-Arms— Bill Fritcher, Larry Hancock, Hall Roach, and Frances Patterson. She also recognized the Senate Pages in attendance— Kimberly Scaniers of Wake County, Zachary Smith of Nash County, Madison Sonzogni of Carteret County, Brianna Baysek of Richmond County, Caroline Harris of Pitt County, Jackson Dumas of Mecklenburg County, and Macie Hasty of Halifax County.

The first order of business was SB161. Senator Krawiec recognized Senator Hise to explain the bill. Senator Hise explained the bill and answered questions from the committee members. Senator Woodard moved for a favorable report on the bill. The motion carried and the bill received a favorable report.

The second order of business was SB218. Senator Krawiec gave the gavel to Senator Hise. Senator D. Davis moved to hear the proposed committee substitute, and the motion carried. Senator Hise recognized Senator Krawiec to explain the bill. Senator Krawiec explained the bill and answered questions from the committee members. The proposed committee substitute was held for the next meeting.

The meeting adjourned at 11:00 AM

Senator Joyce Krawiec
Presiding

Brian Mooney, Committee Clerk

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	April 5, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 161	Conforming Changes LME/MCO Grievances/Appeals.	Senator Hise Senator Pate Senator Krawiec
SB 218	State Health Plan Administrative Changes.-AB	Senator Krawiec Senator Hise Senator Pate

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

Senate Committee on Health Care
Wednesday, April 05, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Senator Joyce Krawiec, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 161	Conforming Changes LME/MCO Grievances/Appeals.	Senator Hise Senator Pate Senator Krawiec
SB 218	State Health Plan Administrative Changes.-AB	Senator Krawiec Senator Hise Senator Pate

Adjournment

SENATE BILL 161: Conforming Changes LME/MCO Grievances/Appeals.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 30, 2017
Introduced by:	Sens. Hise, Pate, Krawiec	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 161 amends the statutes that govern Medicaid enrollees' appeals and grievances related to actions taken by local management entities/managed care organizations (LME/MCOs) to make these statutes conform to changes in the Medicaid federal regulations that recently took effect.***

CURRENT LAW: Chapter 108D of the General Statutes governs the process for Medicaid beneficiaries who are enrolled with an LME/MCO to appeal decisions made by LME/MCOs and to file grievances with LME/MCOs. Medicaid beneficiaries enroll with an LME/MCO in order to receive behavioral health services. The statutes in Chapter 108D allow enrollees to appeal certain LME/MCO actions through an LME/MCO level (first-level) appeal and to appeal the LME/MCO's resolution of the first-level appeal by requesting a contested case hearing with the Office of Administrative Hearings. The statutes also allow enrollees to file grievances with LME/MCOs related to matters that are not subject to appeal.

The State is required to establish procedures for Medicaid enrollee appeals and grievances in accordance with federal managed care regulations in Part 438 of Title 42 of the Code of Federal Regulations. Effective July 5, 2016, changes were made to these federal regulations that conflict with certain provisions in Chapter 108D.

BILL ANALYSIS: **Section 1** amends the definitions pertaining to LME/MCO grievances and appeals by replacing the term "managed care action" with the term "adverse benefit determination" in accordance with a change to that terminology in the federal regulations. Conforming changes are made in **Section 2** and throughout the bill.

Section 3 amends the statute governing standard LME/MCO level enrollee appeals to do the following:

- Allows enrollees 60 days instead of 30 days to request an LME/MCO level appeal after receiving a notice of adverse benefit determination.
- Requires LME/MCOs to resolve an LME/MCO level appeal and send a notice of resolution to the enrollee within 30 days instead of 45 days after receiving the request for appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 4 amends the statute governing expedited LME/MCO level appeals to do the following:

- Requires LME/MCOs to resolve expedited LME/MCO level appeals within 72 hours instead of three working days after receiving the request for expedited appeal.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 5 amends the statute governing enrollee contested case hearings to allow enrollees 120 days instead of 30 days after the mailing date of the notice of resolution to file a request for an appeal at the Office of Administrative Hearings.

EFFECTIVE DATE: The bill would be effective when it becomes law and would apply to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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SENATE BILL 161

Short Title:	Conforming Changes LME/MCO Grievances/Appeals.	(Public)
Sponsors:	Senators Hise, Pate, Krawiec (Primary Sponsors); and Rabin.	
Referred to:	Rules and Operations of the Senate	

March 2, 2017

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE NORTH CAROLINA LME/MCO ENROLLEE GRIEVANCES AND APPEALS STATUTES TO CONFORM WITH RECENT CHANGES TO THE FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108D-1 reads as rewritten:

"**§ 108D-1. Definitions.**

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

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).

~~(1)~~(1a) Applicant. – A provider of mental health, intellectual or developmental disabilities, and substance abuse services who is seeking to participate in the closed network of one or more local management entity/managed care organizations.

(2) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about ~~a managed care action.~~an adverse benefit determination.

(4) Department. – The North Carolina Department of Health and Human Services.

(5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(6) Emergency services. – As defined in 42 C.F.R. § 438.114.

(7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local management entity/managed care organization.

(8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).

(9) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3(20c).

~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~

(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.

(12) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department of Health and Human Services and a local management entity to operate a managed care organization or prepaid

inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed network of one or more local management entity/managed care organizations.

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

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

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

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

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

SECTION 2. G.S. 108D-12(a) reads as rewritten:

"(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than ~~a managed care action.~~an adverse benefit determination. Upon receipt of a grievance, an LME/MCO shall cause a written acknowledgment of receipt of the grievance to be sent by United States mail."

SECTION 3. G.S. 108D-13 reads as rewritten:

"**§ 108D-13. Standard LME/MCO level appeals.**

(a) Notice of ~~Managed Care Action.~~Adverse Benefit Determination. – An LME/MCO shall provide an enrollee with a written notice of ~~a managed care action~~ adverse benefit determination by United States mail as required under 42 C.F.R. § 438.404. The notice of action will employ a standardized form included as a provision in the contracts between the LME/MCOs and the Department of Health and Human Services.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~adverse benefit determination. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal in writing by United States mail.

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

(d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f)."

SECTION 4. G.S. 108D-14 reads as rewritten:

"**§ 108D-14. Expedited LME/MCO level appeals.**

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

...

(d) Notice of Resolution. – If the LME/MCO grants a request for an expedited LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this ~~three-day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~section or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

...."

SECTION 5. G.S. 108D-15 reads as rewritten:

"**§ 108D-15. Contested case hearings on disputed managed care actions.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

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

...

(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

...

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

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

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

(3) A preprinted statement that indicates that the enrollee would like to appeal a specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

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

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

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

...

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

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

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

(3) Failed to use proper procedure.

(4) Acted arbitrarily or capriciously.

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

...."

SECTION 6. This act is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2017

Legislative Actuarial Note
Health Benefits

BILL NUMBER: Senate Bill 218 (First Edition)

SHORT TITLE: State Health Plan Administrative Changes.-AB

SPONSOR(S): Senators Krawiec, Hise, and Pate

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

Section 1: Amends G.S. 135-48.44(a) to allow the Plan to terminate coverage when an individual knowingly and willfully provides false information during the enrollment process. Currently, the Plan can terminate coverage when an individual provides false information related to a claim.

Section 2: Amends G.S. 135-48.40(c)(2) to clarify that the retiree's premium for one-half contributory coverage is half of the employer contribution established by the General Assembly plus the employee contribution.

Section 3: Amends G.S. 135-48.42(a) to require members to enroll newborns they wish to cover within 30 days of birth. Currently, additional children born to a member who has elected employee-child or family coverage are automatically covered.

Sections 4-6: Allow the State Treasurer, subject to approval by the Board of Trustees, to set aside up to 50% of any unencumbered balance to reduce the State's unfunded accrued liability for retiree medical benefits.

Section 7: Provides limited civil immunity to members of the Board of Trustees.

EFFECTIVE DATE: Section 3 becomes effective October 1, 2017 and applies to children born on or after that date. The remainder of the bill is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

The Segal Company, the actuary for the Plan, estimates that the bill will have negligible financial impact on the Plan. However, The Segal Company notes that if funds are set aside under Sections 4-6, then they may need to be reimbursed through higher premium contributions in future years.

Hartman & Associates, the actuary for the General Assembly, also estimates that Sections 1-3 and 7 will not have a material impact on the Plan. Hartman & Associates notes that it is likely that any amount set

aside under Sections 4-6 would increase the magnitude of future premium increases or benefit reductions, although we do not know the likelihood or amount of any transfers that may be made.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments and charter schools may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

The State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement, with the exception of many Medicare-eligible retirees who are in fully-insured Medicare Advantage plans. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who participate in a plan with a non-zero premium or who elect dependent coverage. Benefit and premium changes are typically effective at January 1. The Plan's PPO benefit design includes three alternative benefit levels listed below:

1) The "Traditional" 70/30 plan that offers higher out-of pocket requirements in return for lower employee and retiree premiums and only one wellness activity,

2) The "Enhanced" 80/20 plan that offers lower out-of-pocket requirements with higher employee and retiree premiums, which can be lowered by completing three wellness activities, and

3) The Consumer-Directed Health Plan (CDHP) that applies deductibles and co-insurance to all services and offers lower employee and retiree premiums if one completes wellness activities

Medicare-eligible retirees are offered three alternative plans:

1) The "Traditional" 70/30 plan as coverage secondary to Medicare for medical services plus a pharmacy benefit plan,

2) "Base" Medicare Advantage Prescription Drug Plan (MA-PDP) from United Healthcare, that is actuarially equivalent to the "Enhanced" 80/20 Plan and applies in-network out-of-pocket requirements at out-of-network providers

3) "Enhanced" MA-PDP, identical to the "Base" MA-PDP, except with lower co-pays and higher retiree premiums

The following tables provide a summary of the most common monthly premium rates for the Plan in 2017:

Active Employees and Non-Medicare Retirees (if Fully Subsidized)

	Employer Share	Employee/Retiree Share	
		Complete All Wellness Activities *	Complete No Wellness Activities
Traditional 70/30 Plan	$479.48	$0.00	$40.00
Enhanced 80/20 Plan	$479.48	$15.04	$105.04
Consumer-Directed Health Plan (85/15)	$479.48	$0.00	$80.00

* Members receive credits for each activity. We have shown all or none for simplicity.

Medicare Retirees (if Fully Subsidized)

Medicare Advantage Plans

	Employer Share	Employee/Retiree Share
MA-PDP Base Plan	$372.56	$0.00
MA-PDP Enhanced Plan	$372.56	$64.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$372.56	$0.00

Dependents (paid by employee/retiree in addition to premiums above)

	All Dependents are Non-Medicare			One or More Medicare Dependents		
	Traditional 70/30	Enhanced 80/20	CDHP 85/15	MA-PDP Base	MA-PDP Enhanced	Traditional 70/30
Employee/Retiree + Children	$218.14	$290.14	$196.32	$124.80	$188.80	$155.20
Employee/Retiree + Spouse	$562.10	$668.48	$505.90	$124.80	$188.80	$408.08
Employee/Retiree + Family	$598.70	$708.72	$538.82	$249.60	$377.60	$444.66

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2016-17, employers contribute 5.81% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $950 million.

Financial Condition

Projected Results for CY 2017 and CY 2018 – The following summarizes projected financial results for 2017 and 2018, based on financial experience through September 2016. The projection assumes a 7.0% annual claims growth trend for medical claims, an 8.5% trend for pharmacy claims, benefit provisions and member-paid premiums as currently adopted by the Board, and 3.5% premium increases in 2018.

	($ millions) Projected CY 2017	Projected CY 2018
Beginning Cash Balance	$945.7	$834.1
Receipts:		
Net Premium Collections	$3,264.8	$3,369.6
Medicare Subsidies	$16.5	$16.6
Investment Earnings	$7.2	$6.2
Total	$3,288.5	$3,392.4
Disbursements:		
Net Medical Claim Payment Expenses	$2,271.9	$2,374.3
Net Pharmacy Claim Payment Expenses	$706.9	$787.2
Medicare Advantage Premiums	$192.6	$255.4
Administration and Claims-Processing Expenses	$228.7	$219.6
Total	$3,400.1	$3,636.5
Net Operating Income (Loss)	($111.6)	($244.1)

Of the premiums paid in CY 2017, an estimated $2.1 billion is derived from General Fund sources and an estimated $0.1 billion is derived from Highway Fund sources.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, fraud detection, and other authorized actions by the State Treasurer, Executive Administrator, and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Medical claim costs are expected to increase at a rate of 7.0% annually and pharmacy claim costs are expected to increase at a rate of 8.5% annually according to assumptions adopted by the Board of Trustees. The active population is projected to decline by 1% per year and the retired population is projected to increase by 1% per year.

Enrollment as of January 1, 2017

I. No. of Participants	Traditional 70/30	Enhanced 80/20	Consumer Directed	Medicare Advantage	Total	Percent of Total
Actives						
Employees	125,378	163,187	21,119	-	309,684	43.3%
Dependents	75,032	73,137	21,903	-	170,072	23.8%
Sub-total	200,410	236,324	43,022	-	479,756	67.1%
Retired						
Employees	59,349	25,367	1,671	111,890	198,277	27.7%
Dependents	8,029	4,182	903	9,447	22,561	3.2%
Sub-total	67,378	29,549	2,574	121,337	220,838	30.9%
Other						
Employees	2,618	5,921	980	-	9,519	1.3%
Dependents	1,522	2,368	767	-	4,657	0.7%
Sub-total	4,140	8,289	1,747	-	14,176	2.0%
Total						
Employees	187,345	194,475	23,770	111,890	517,480	72.4%
Dependents	84,583	79,687	23,573	9,447	197,290	27.6%
Grand Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**	**100%**
Percent of Total	**38.0%**	**38.4%**	**6.6%**	**17.0%**	**100.0%**	

II. Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	144,962	154,308	12,663	102,443	414,376
Employee Child(ren)	25,805	26,363	5,739	179	58,086
Employee Spouse	6,105	5,106	1,533	9,268	22,012
Employee Family	10,473	8,698	3,835		23,006
Total	**187,345**	**194,475**	**23,770**	**111,890**	**517,480**

Percent Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	77.4%	79.3%	53.3%	91.6%	80.1%
Employee Child(ren)	13.8%	13.6%	24.1%	0.2%	11.2%
Employee Spouse	3.3%	2.6%	6.4%	8.3%	4.3%
Employee Family	5.6%	4.5%	16.1%	0.0%	4.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	159,441	178,330	26,685	80,445	444,901
Male	112,487	95,832	20,658	40,892	269,869
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	58.6%	65.0%	56.4%	66.3%	62.2%
Male	41.4%	35.0%	43.6%	33.7%	37.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	73,899	70,290	18,777	3	162,969
26 to 45	68,332	76,095	13,837	228	158,492
46 to 55	46,137	56,424	8,217	873	111,651
56 to 65	47,542	66,377	6,204	11,420	131,543
66 & Over	36,018	4,976	308	108,813	150,115
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	27.2%	25.6%	39.7%	0.0%	22.8%
26 to 45	25.1%	27.8%	29.2%	0.2%	22.2%
46 to 55	17.0%	20.6%	17.4%	0.7%	15.6%
56 to 65	17.5%	24.2%	13.1%	9.4%	18.4%
66 & Over	13.2%	1.8%	0.7%	89.7%	21.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	48,342	11,835	60,177
Medicare Eligible in Traditional 70/30	38,045	1,279	39,324
Medicare Eligible in Base Medicare Advantage Plans	93,707	6,871	100,578
Medicare Eligible in Enhanced Medicare Advantage Plans	18,183	2,576	20,759
Total	**198,277**	**22,561**	**220,838**

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	24.4%	52.5%	27.2%
Medicare Eligible in Traditional 70/30	19.2%	5.7%	17.8%
Medicare Eligible in Base Medicare Advantage Plans	47.3%	30.5%	45.5%
Medicare Eligible in Enhanced Medicare Advantage Plans	9.2%	11.4%	9.4%
Total	**100.0%**	**100.0%**	**100.0%**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	68,024	32,792	100,816
UNC System	52,910	34,217	87,127
Local Public Schools	168,892	91,264	260,156
Charter Schools (88 entities)	4,111	2,688	6,799
Local Community Colleges	15,747	9,111	24,858
Other			
Local Goverments (91 entities)	8,882	4,128	13,010
COBRA	637	529	1,166
Sub-total	319,203	174,729	493,932
Retirement System *	198,277	22,561	220,838
Total	**517,480**	**197,290**	**714,770**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	13.1%	16.6%	14.1%
UNC System	10.2%	17.3%	12.2%
Local Public Schools	32.6%	46.3%	36.4%
Charter Schools	0.8%	1.4%	1.0%
Local Community Colleges	3.0%	4.6%	3.5%
Other			
Local Goverments	1.7%	2.1%	1.8%
COBRA	0.1%	0.3%	0.2%
Sub-total	61.7%	88.6%	69.1%
Retirement System	38.3%	11.4%	30.9%
Total	**100.0%**	**100.0%**	**100.0%**

* Includes 6 employees and 6 dependents covered as firefighters, rescue squad workers, or National Guard members

SOURCES OF DATA:

The Segal Company; baseline financial projections updated through Q3 CY2016 with 3.52% employer and employee premium increase in 2018, no further increases in wellness premiums/credits; dated January 24, 2017. Filename "CY16 Q3 - New Baseline - S1 - No Credit Increase in 2018+.pdf"

-Actuarial Note, Hartman & Associates, "House Bill 299/Senate Bill 218: An Act Make Clarifying and Administrative Changes to the Laws Relating to the State Health Plan for Teachers and State Employees", March 14, 2017, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, Senate Bill 218, "State Health Plan Administrative Changes-AB", March 27, 2017, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

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DATE: March 27, 2017

Signed Copy Located in the NCGA Principal Clerk's Offices

SENATE BILL 218:
State Health Plan Administrative Changes.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations on Pensions, Compensation, and Benefits. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 29, 2017
Introduced by:	Sens. Krawiec, Hise, Pate	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	PCS to First Edition S218-CSBC-9		

OVERVIEW: Senate Bill 218 would make administrative changes to statutes governing the North Carolina State Health Plan for Teachers and State Employees (Plan) that: 1) allow revocation of coverage for misrepresentations made by covered individuals; 2) pertain to the premium split between the state and certain General Assembly retirees; 3) provide coverage to children newly born to existing covered employees; 4) prioritize the order in which excess funds in the Public Employee Health Benefit Fund are used; 5) grant powers to the Board of Trustees and State Treasurer pertaining to the unfunded actuarial liability; and 6) provide members of the Board of Trustees with immunity from civil liability for most actions taken in their official capacity.

[As introduced, this bill was identical to H299, as introduced by Reps. Dobson, Corbin, Clampitt, Henson, which is currently in House Insurance.]

CURRENT LAW: When appropriate, the current law is in italics.

BILL ANALYSIS:

Section 1 would amend G.S. 135-48.44(a)(6) to clarify that an individual would lose coverage under the plan on the last day of the month the individual is found to have made a false representation of a material fact regarding eligibility or enrollment information.

Currently, individuals lose coverage only if they make false representations of material facts in a claim for reimbursement.

Section 2 would amend G.S. 135-48.40(c)(2) pertaining to one-half contributory coverage to clarify that General Assembly members and employees with 10 but less than 20 years of retirement service credit will have the State pay 50% of the balance toward their employer premiums, and the members and employees shall pay the balance of the total premium unless prohibited by law. Section 2 also amends G.S. 135-48.40(c)(2) to define "total premium" as the sum of the Plan's employer contribution rate and the employee or retiree's contribution rate.

Current law does not include the "unless prohibited by law" exception to the premium split or define the term "total premium."

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 3 would amend G.S. 135-48.42(a) pertaining to enrollment to clarify that children born to covered employees will be covered from birth so long as the participants notify the Plan within 30 days of birth and pay premiums retroactive to the first day of the month in which the child was born.

Section 4 would amend G.S. 135-48.5(a), which creates two health benefit trust funds, the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund, to clarify the order for using funds in the Public Employee Health Benefit Fund that are in excess of the amount needed to pay benefit and administrative costs. The excess funds shall be used in the following order:

- First, to establish a reserve for incurred but unpresented claims.
- Second, to be set aside to reduce the Plan's unfunded actuarial accrued liability for post-employment retiree health benefits. Any amount set aside must be approved by the Board of Trustees and limited to no more than 50% of the excess funds in the Public Employee Health Benefit Fund after establishing a reserve for incurred but unpresented claims.
- Third, to reduce the premiums required by the Plan.
- Fourth, to improve the Plan as provided by the State Treasurer, subject to approval by the Board of Trustees.

Currently there is no provision to use the excess funds to be set aside to reduce unfunded actuarial accrued liability for post-employment retiree health benefits, and the General Assembly, not the State Treasurer, has the authority to use finds to improve the Plan

Section 5 would amend G.S. 135-48.22, pertaining to the powers and duties of the trustees, to include the ability to approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits in the powers delegated to the Board of Trustees.

Section 6 would amend G.S.135-48.30(a), which outlies the powers and duties of the State Treasurer to provide that the State Treasurer the power to set aside funds from the Plan to reduce the Plan's unfunded actuarial accrued liability for post-employment retiree health benefits.

Section 7 would amend G.S. 135-48.20, which established the Board of Trustees to add a new subsection making individual members of the Board of Trustees immune from civil liability for actions taken in their official capacity except when:

- The member was not acting within the scope of the member's duties.
- The member was not acting in good faith.
- The member committed gross negligence or willful or wonton misconduct.
- The member derived an improper personal financial benefit from a transaction.
- The member incurred liability from the operation of a motor vehicle.

Section 8 would amend the definitions for the Plan in G.S. 135-48.1 to add a definition for "Authorized representatives who are assisting the State Health Plan Division staff." The definition used is the same as the one in the Local Governmental Employees' Retirement System (LGERS) and Teachers' and State Employees' Retirement System (TSERS) statutes.

Section 9 would add several new provisions to the Plan related to fraud detection and audit programs.

The first provision, substantially similar to those in LGERS and TSERS, would allow the Plan or its representatives to have access to people, books, records, reports, vouchers, correspondence, files, and investments of any employing unit, and the authority to inspect and make copies of that information.

The Plan or its representatives would also have access to people, records, papers, reports, vouchers, correspondence, and books in the possession of any person or organization that pertain to benefits handled pursuant to a grant or contract with the federal government, the State, or any political subdivision of the State.

Providers of social and medical services who provide access to the Plan must make copies of records maintained for services provided to beneficiaries and provide those copies to the Plan or its representatives when the Plan requests the documentation in writing. Requests must state the purpose and authority for the request and allow a reasonable time to produce the documents. Similar provisions are found in LGERS and TSERS.

Section 9 would also establish a records retention policy, similar to the LGERS and TSERS policies. The Plan would be required to maintain complete files of investigative reports for ten years, with those files being retained according to an agreement between the Plan and the State Archives. The files must be kept confidential; however, at the discretion of the Executive Administrator of the Plan the records may be made available to a representative of the State or federal government in connection with an official matter or criminal investigation. The records may also be disclosed if an order requiring disclosure is issued in Wake County Superior Court.

Section 10 would amend G.S. 105-259(b), pertaining to the disclosure of tax records, to allow State employees who have access to tax information to disclose information requested by the State Treasurer in connection with an investigation under G.S. 135-6(q), G.S. 135-48.16, or G.S. 128.28(r).

EFFECTIVE DATE: Section 3 would be effective October 1, 2017, and apply to children born to covered employees on or after that date. The remainder of bill would become effective when it becomes law.

SENATE BILL 218*

Short Title:	State Health Plan Administrative Changes.-AB	(Public)
Sponsors:	Senators Krawiec, Hise, and Pate (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND ADMINISTRATIVE CHANGES TO THE LAWS RELATING TO THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.44(a) reads as rewritten:

"**§ 135-48.44. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

...

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact regarding eligibility or enrollment information or in a claim for reimbursement of medical services under the Plan. The State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the State Treasurer to make an exception as allowed for under this subdivision.

...."

SECTION 2. G.S. 135-48.40(c)(2) reads as rewritten:

"(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the ~~State.~~State unless prohibited by law. The total premium is the sum of the Plan's total employer premium contribution rate plus the employee or retiree's contribution for individual and dependent coverage."

SECTION 3.(a) G.S. 135-48.42(a) reads as rewritten:

"(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory or other contributory basis. Coverage may become effective on the first day of the month following date of

entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees ~~having coverage type (2) or (3), as outlined in G.S. 135-48.43(d)~~ shall be ~~automatically~~ covered at the time of birth ~~without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions~~ so long as the ~~claims processor~~ Plan receives notification within 30 days of the date of ~~birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that~~ birth and the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born."

SECTION 3.(b) This section becomes effective October 1, 2017, and applies to children born to covered employees on or after that date.

SECTION 4. G.S. 135-48.5(a) reads as rewritten:

"(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used ~~first,~~ in the following order:

(1) First, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented ~~claims, second,~~ claims.

(2) Second, up to fifty percent (50%) of any unencumbered balance remaining after providing for incurred but unpresented claims may be set aside by the State Treasurer, subject to approval by the Board of Trustees, to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits.

(3) Third, to reduce the premiums required in providing the benefits of the health benefits ~~programs, and third~~ programs.

(4) Fourth, to improve the plan, as may be provided by the ~~General Assembly.~~State Treasurer, subject to approval by the Board of Trustees.

The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein. The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3."

SECTION 5. G.S. 135-48.22 is amended by adding a new subdivision to read:

"(7) Approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a) and G.S. 135-48.30(a)(18)."

SECTION 6. G.S. 135-48.30(a) is amended by adding a new subdivision to read:

"(18) Set aside funds from the Public Employee Health Benefit Fund to reduce the State unfunded actuarial accrued liability for post-employment retiree health

benefits as provided in G.S. 135-48.5(a), subject to approval by the Board of Trustees."

SECTION 7. G.S. 135-48.20 is amended by adding a new subsection to read:

"(n) Immunity. – Except to the extent provided under Article 31A of Chapter 143 of the General Statutes and to the extent of insurance coverage purchased pursuant to G.S. 58-32-15, a person serving on the Board of Trustees shall be immune individually from civil liability for monetary damages for any act, or failure to act, arising out of that service, except where any of the following apply:

(1) The person was not acting within the scope of that person's official duties.

(2) The person was not acting in good faith.

(3) The person committed gross negligence or willful or wanton misconduct that resulted in damages or injury.

(4) The person derived an improper personal financial benefit, either directly or indirectly, from the transaction.

(5) The person incurred the liability from the operation of a motor vehicle."

SECTION 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S D

SENATE BILL 218
PROPOSED COMMITTEE SUBSTITUTE S218-CSBC-9 [v.3]
03/29/2017 05:55:34 PM

Short Title: State Health Plan Administrative Changes.-AB (Public)

Sponsors:

Referred to:

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND ADMINISTRATIVE CHANGES TO THE LAWS RELATING TO THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.44(a) reads as rewritten:

"**§ 135-48.44. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

...

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact regarding eligibility or enrollment information or in a claim for reimbursement of medical services under the Plan. The State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the State Treasurer to make an exception as allowed for under this subdivision.

...."

SECTION 2. G.S. 135-48.40(c)(2) reads as rewritten:

"(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the ~~State~~.State unless prohibited by law. The total premium is the sum of the Plan's total employer premium contribution rate plus the employee or retiree's contribution for individual and dependent coverage."

SECTION 3.(a) G.S. 135-48.42(a) reads as rewritten:

"(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially

contributory or other contributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees ~~having coverage type (2) or (3), as outlined in G.S. 135-48.43(d)~~ shall be ~~automatically~~ covered at the time of birth ~~without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions~~ so long as the ~~claims processor~~ Plan receives notification within 30 days of the date of ~~birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that~~ birth and the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born."

SECTION 3.(b) This section becomes effective October 1, 2017, and applies to children born to covered employees on or after that date.

SECTION 4. G.S. 135-48.5(a) reads as rewritten:

"(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used ~~first,~~ in the following order:

(1) First, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented ~~claims, second,~~ claims.

(2) Second, up to fifty percent (50%) of any unencumbered balance remaining after providing for incurred but unpresented claims may be set aside by the State Treasurer, subject to approval by the Board of Trustees, to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits.

(3) Third, to reduce the premiums required in providing the benefits of the health benefits ~~programs, and third~~ programs.

(4) Fourth, to improve the plan, as may be provided by the ~~General Assembly.~~State Treasurer, subject to approval by the Board of Trustees.

The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein. The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3."

SECTION 5. G.S. 135-48.22 is amended by adding a new subdivision to read:

"(7) Approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a) and G.S. 135-48.30(a)(18)."

SECTION 6. G.S. 135-48.30(a) is amended by adding a new subdivision to read:

"(18) Set aside funds from the Public Employee Health Benefit Fund to reduce the State unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a), subject to approval by the Board of Trustees."

SECTION 7. G.S. 135-48.20 is amended by adding a new subsection to read:

"(n) Immunity. – Except to the extent provided under Article 31A of Chapter 143 of the General Statutes and to the extent of insurance coverage purchased pursuant to G.S. 58-32-15, a person serving on the Board of Trustees shall be immune individually from civil liability for monetary damages for any act, or failure to act, arising out of that service, except where any of the following apply:

(1) The person was not acting within the scope of that person's official duties.

(2) The person was not acting in good faith.

(3) The person committed gross negligence or willful or wanton misconduct that resulted in damages or injury.

(4) The person derived an improper personal financial benefit, either directly or indirectly, from the transaction.

(5) The person incurred the liability from the operation of a motor vehicle."

SECTION 8. G.S. 135-48.1 reads as rewritten:

"**§ 135-48.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

(1) Authorized representatives who are assisting the State Health Plan Division staff. – Staff of the Department of the State Treasurer, staff of the Department of Justice, or persons providing internal auditing assistance required under G.S. 143-746(b).

(1a) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

...."

SECTION 9. Part 1 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-48.16. Fraud detection and audit programs.**

(a) Access to Persons and Records. – In the course of conducting an investigation or a audit under G.S. 135-48.30(a)(9), the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall have ready access to the following:

(1) Persons, books, records, reports, vouchers, correspondence, files, personnel files, investments, and any other documentation of any employing unit. The Plan shall have the authority to both examine and make copies of the information described in this subdivision The review of State tax returns shall be limited to matters of official business, and the Plan's report shall not violate the confidentiality provisions of the tax laws.

(2) Persons, records, papers, reports, vouchers, correspondence, books, and any other documentation that is in the possession of any individual, private corporation, institution, association, board, or other organization that pertain to any benefits received, disbursed, or otherwise handled pursuant to a grant or contract from the federal government, the State, or its political subdivisions. Providers of social and medical services to a beneficiary shall make copies of records they maintain for services provided to the beneficiary.

(b) Records of Providers of Social and Medical Services. – Providers of social and medical services who provide ready access to the Plan under subdivision (2) of subsection (a)

of this section shall make copies of records they maintain for services provided to a beneficiary available to the Plan or to the authorized representatives who are assisting the State Health Plan Division staff. The Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall request records in writing by providing the name of each beneficiary from whom records are sought, the purpose of the request, the authority for the request, and a reasonable period of time for the production of record copies by the provider. A provider may charge, and the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall, in accordance with G.S. 90-411, pay a reasonable fee to the provider for copies of the records provided.

(c) Fraud Detection and Audit Reports and Work Papers. – The Plan shall maintain for 10 years a complete file of all compliance investigative reports, fraud investigative reports, and reports of other examinations, investigations, surveys, and reviews issued under the Plan's authority under G.S. 135-48.30(a)(9). Fraud or compliance investigation work papers and other evidence or related supportive material directly pertaining to the work of the State Health Plan Division of the Department of State Treasurer shall be retained according to an agreement between the Plan and State Archives. To promote intergovernmental cooperation and avoid unnecessary duplication of fraud investigative effort, and notwithstanding local unit personnel policies to the contrary, pertinent work papers and other supportive material relating to issued fraud or compliance investigation reports may be, at the discretion of the Executive Administrator of the Plan, and unless otherwise prohibited by law, made available for inspection by duly authorized representatives of the State and federal government who desire access to, and inspection of, such records in connection with some matter officially before them, including criminal investigations. Except as provided in this section, or upon an order issued in Wake County Superior Court upon 10 days' notice and hearing finding that access is necessary to a proper administration of justice, fraud investigation work papers and related supportive material shall be kept confidential, including any information developed as a part of the investigation."

SECTION 10. G.S. 105-259(b) is amending by adding a new subdivision to read:

"(39a) To furnish the Department of State Treasurer with information it requests related to an investigation or audit under G.S. 135-6(q), 135-48.16, or 128-28(r)."

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2017

Legislative Actuarial Note
Health Benefits

BILL NUMBER: Senate Bill 218 (First Edition)

SHORT TITLE: State Health Plan Administrative Changes.-AB

SPONSOR(S): Senators Krawiec, Hise, and Pate

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

Section 1: Amends G.S. 135-48.44(a) to allow the Plan to terminate coverage when an individual knowingly and willfully provides false information during the enrollment process. Currently, the Plan can terminate coverage when an individual provides false information related to a claim.

Section 2: Amends G.S. 135-48.40(c)(2) to clarify that the retiree's premium for one-half contributory coverage is half of the employer contribution established by the General Assembly plus the employee contribution.

Section 3: Amends G.S. 135-48.42(a) to require members to enroll newborns they wish to cover within 30 days of birth. Currently, additional children born to a member who has elected employee-child or family coverage are automatically covered.

Sections 4-6: Allow the State Treasurer, subject to approval by the Board of Trustees, to set aside up to 50% of any unencumbered balance to reduce the State's unfunded accrued liability for retiree medical benefits.

Section 7: Provides limited civil immunity to members of the Board of Trustees.

EFFECTIVE DATE: Section 3 becomes effective October 1, 2017 and applies to children born on or after that date. The remainder of the bill is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

The Segal Company, the actuary for the Plan, estimates that the bill will have negligible financial impact on the Plan. However, The Segal Company notes that if funds are set aside under Sections 4-6, then they may need to be reimbursed through higher premium contributions in future years.

Hartman & Associates, the actuary for the General Assembly, also estimates that Sections 1-3 and 7 will not have a material impact on the Plan. Hartman & Associates notes that it is likely that any amount set

aside under Sections 4-6 would increase the magnitude of future premium increases or benefit reductions, although we do not know the likelihood or amount of any transfers that may be made.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments and charter schools may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

The State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement, with the exception of many Medicare-eligible retirees who are in fully-insured Medicare Advantage plans. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who participate in a plan with a non-zero premium or who elect dependent coverage. Benefit and premium changes are typically effective at January 1. The Plan's PPO benefit design includes three alternative benefit levels listed below:

1) The "Traditional" 70/30 plan that offers higher out-of pocket requirements in return for lower employee and retiree premiums and only one wellness activity,

2) The "Enhanced" 80/20 plan that offers lower out-of-pocket requirements with higher employee and retiree premiums, which can be lowered by completing three wellness activities, and

3) The Consumer-Directed Health Plan (CDHP) that applies deductibles and co-insurance to all services and offers lower employee and retiree premiums if one completes wellness activities

Medicare-eligible retirees are offered three alternative plans:

1) The "Traditional" 70/30 plan as coverage secondary to Medicare for medical services plus a pharmacy benefit plan,

2) "Base" Medicare Advantage Prescription Drug Plan (MA-PDP) from United Healthcare, that is actuarially equivalent to the "Enhanced" 80/20 Plan and applies in-network out-of-pocket requirements at out-of-network providers

3) "Enhanced" MA-PDP, identical to the "Base" MA-PDP, except with lower co-pays and higher retiree premiums

The following tables provide a summary of the most common monthly premium rates for the Plan in 2017:

Active Employees and Non-Medicare Retirees (if Fully Subsidized)

	Employer Share	Employee/Retiree Share	
		Complete All Wellness Activities *	Complete No Wellness Activities
Traditional 70/30 Plan	$479.48	$0.00	$40.00
Enhanced 80/20 Plan	$479.48	$15.04	$105.04
Consumer-Directed Health Plan (85/15)	$479.48	$0.00	$80.00

* Members receive credits for each activity. We have shown all or none for simplicity.

Medicare Retirees (if Fully Subsidized)

Medicare Advantage Plans

	Employer Share	Employee/Retiree Share
MA-PDP Base Plan	$372.56	$0.00
MA-PDP Enhanced Plan	$372.56	$64.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$372.56	$0.00

Dependents (paid by employee/retiree in addition to premiums above)

	All Dependents are Non-Medicare			One or More Medicare Dependents		
	Traditional 70/30	Enhanced 80/20	CDHP 85/15	MA-PDP Base	MA-PDP Enhanced	Traditional 70/30
Employee/Retiree + Children	$218.14	$290.14	$196.32	$124.80	$188.80	$155.20
Employee/Retiree + Spouse	$562.10	$668.48	$505.90	$124.80	$188.80	$408.08
Employee/Retiree + Family	$598.70	$708.72	$538.82	$249.60	$377.60	$444.66

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2016-17, employers contribute 5.81% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $950 million.

Financial Condition

Projected Results for CY 2017 and CY 2018 – The following summarizes projected financial results for 2017 and 2018, based on financial experience through September 2016. The projection assumes a 7.0% annual claims growth trend for medical claims, an 8.5% trend for pharmacy claims, benefit provisions and member-paid premiums as currently adopted by the Board, and 3.5% premium increases in 2018.

	($ millions) Projected CY 2017	Projected CY 2018
Beginning Cash Balance	$945.7	$834.1
Receipts:		
Net Premium Collections	$3,264.8	$3,369.6
Medicare Subsidies	$16.5	$16.6
Investment Earnings	$7.2	$6.2
Total	$3,288.5	$3,392.4
Disbursements:		
Net Medical Claim Payment Expenses	$2,271.9	$2,374.3
Net Pharmacy Claim Payment Expenses	$706.9	$787.2
Medicare Advantage Premiums	$192.6	$255.4
Administration and Claims-Processing Expenses	$228.7	$219.6
Total	$3,400.1	$3,636.5
Net Operating Income (Loss)	($111.6)	($244.1)

Of the premiums paid in CY 2017, an estimated $2.1 billion is derived from General Fund sources and an estimated $0.1 billion is derived from Highway Fund sources.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, fraud detection, and other authorized actions by the State Treasurer, Executive Administrator, and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Medical claim costs are expected to increase at a rate of 7.0% annually and pharmacy claim costs are expected to increase at a rate of 8.5% annually according to assumptions adopted by the Board of Trustees. The active population is projected to decline by 1% per year and the retired population is projected to increase by 1% per year.

Enrollment as of January 1, 2017

I. No. of Participants	Traditional 70/30	Enhanced 80/20	Consumer Directed	Medicare Advantage	Total	Percent of Total
Actives						
Employees	125,378	163,187	21,119	-	309,684	43.3%
Dependents	75,032	73,137	21,903	-	170,072	23.8%
Sub-total	200,410	236,324	43,022	-	479,756	67.1%
Retired						
Employees	59,349	25,367	1,671	111,890	198,277	27.7%
Dependents	8,029	4,182	903	9,447	22,561	3.2%
Sub-total	67,378	29,549	2,574	121,337	220,838	30.9%
Other						
Employees	2,618	5,921	980	-	9,519	1.3%
Dependents	1,522	2,368	767	-	4,657	0.7%
Sub-total	4,140	8,289	1,747	-	14,176	2.0%
Total						
Employees	187,345	194,475	23,770	111,890	517,480	72.4%
Dependents	84,583	79,687	23,573	9,447	197,290	27.6%
Grand Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**	**100%**
Percent of Total	**38.0%**	**38.4%**	**6.6%**	**17.0%**	**100.0%**	

II. Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	144,962	154,308	12,663	102,443	414,376
Employee Child(ren)	25,805	26,363	5,739	179	58,086
Employee Spouse	6,105	5,106	1,533	9,268	22,012
Employee Family	10,473	8,698	3,835		23,006
Total	**187,345**	**194,475**	**23,770**	**111,890**	**517,480**

Percent Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	77.4%	79.3%	53.3%	91.6%	80.1%
Employee Child(ren)	13.8%	13.6%	24.1%	0.2%	11.2%
Employee Spouse	3.3%	2.6%	6.4%	8.3%	4.3%
Employee Family	5.6%	4.5%	16.1%	0.0%	4.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	159,441	178,330	26,685	80,445	444,901
Male	112,487	95,832	20,658	40,892	269,869
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	58.6%	65.0%	56.4%	66.3%	62.2%
Male	41.4%	35.0%	43.6%	33.7%	37.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	73,899	70,290	18,777	3	162,969
26 to 45	68,332	76,095	13,837	228	158,492
46 to 55	46,137	56,424	8,217	873	111,651
56 to 65	47,542	66,377	6,204	11,420	131,543
66 & Over	36,018	4,976	308	108,813	150,115
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	27.2%	25.6%	39.7%	0.0%	22.8%
26 to 45	25.1%	27.8%	29.2%	0.2%	22.2%
46 to 55	17.0%	20.6%	17.4%	0.7%	15.6%
56 to 65	17.5%	24.2%	13.1%	9.4%	18.4%
66 & Over	13.2%	1.8%	0.7%	89.7%	21.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	48,342	11,835	60,177
Medicare Eligible in Traditional 70/30	38,045	1,279	39,324
Medicare Eligible in Base Medicare Advantage Plans	93,707	6,871	100,578
Medicare Eligible in Enhanced Medicare Advantage Plans	18,183	2,576	20,759
Total	**198,277**	**22,561**	**220,838**

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	24.4%	52.5%	27.2%
Medicare Eligible in Traditional 70/30	19.2%	5.7%	17.8%
Medicare Eligible in Base Medicare Advantage Plans	47.3%	30.5%	45.5%
Medicare Eligible in Enhanced Medicare Advantage Plans	9.2%	11.4%	9.4%
Total	**100.0%**	**100.0%**	**100.0%**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	68,024	32,792	100,816
UNC System	52,910	34,217	87,127
Local Public Schools	168,892	91,264	260,156
Charter Schools (88 entities)	4,111	2,688	6,799
Local Community Colleges	15,747	9,111	24,858
Other			
Local Goverments (91 entities)	8,882	4,128	13,010
COBRA	637	529	1,166
Sub-total	319,203	174,729	493,932
Retirement System *	198,277	22,561	220,838
Total	**517,480**	**197,290**	**714,770**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	13.1%	16.6%	14.1%
UNC System	10.2%	17.3%	12.2%
Local Public Schools	32.6%	46.3%	36.4%
Charter Schools	0.8%	1.4%	1.0%
Local Community Colleges	3.0%	4.6%	3.5%
Other			
Local Goverments	1.7%	2.1%	1.8%
COBRA	0.1%	0.3%	0.2%
Sub-total	61.7%	88.6%	69.1%
Retirement System	38.3%	11.4%	30.9%
Total	**100.0%**	**100.0%**	**100.0%**

* Includes 6 employees and 6 dependents covered as firefighters, rescue squad workers, or National Guard members

SOURCES OF DATA:

The Segal Company; baseline financial projections updated through Q3 CY2016 with 3.52% employer and employee premium increase in 2018, no further increases in wellness premiums/credits; dated January 24, 2017. Filename "CY16 Q3 - New Baseline - S1 - No Credit Increase in 2018+.pdf"

-Actuarial Note, Hartman & Associates, "House Bill 299/Senate Bill 218: An Act Make Clarifying and Administrative Changes to the Laws Relating to the State Health Plan for Teachers and State Employees", March 14, 2017, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, Senate Bill 218, "State Health Plan Administrative Changes-AB", March 27, 2017, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: David Vanderweide

APPROVED BY:

Mark Trogdon, Director
Fiscal Research Division

DATE: March 27, 2017

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, April 05, 2017

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

FAVORABLE

SB **161** Conforming Changes LME/MCO Grievances/Appeals.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Ralph Hise will handle SB 161

VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

April
[redacted]05, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Wendy Kelly	Forum Carolina
Peyton Maynard	
[redacted]	ACMS
~~Tony~~ Thompson	HPC
Rob Lagumt	RLA
	C C-A
Brian Perkins	Alliance BHC
Adam Sholar	NCHCFA
Lanier Hodgson	UNC HCS
Christine Cray	WakeMed
Daniel VanLiere	Vidant
LT McCrimmon	DHHS
Cory Hamb	NCHA
Lori Kroll	Novant Health
Brandon Hargrove	BCBSNC
Jason Jones	BCBSNC
Marla Gray	BCBSNC

TARA Feeds — Benchmarks

09-21-201

VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

April 05, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
JERRY COHEN	NM
Christine Wleason	AES CAN
Ben Popkin	DHHS
Flint Benson	SEANC
David Collins	SEANC
Robb Jansen	NCSBE
[illegible]	[illegible]
[illegible]	[illegible]
Tom Nesbit	NCICU
Sue Ann Forrest	NCMS
Casey Jarvis	DHHS
Sarah Ball	5 Pt
[illegible]	NCFPC
[illegible]	CSS
[illegible]	[illegible]
[illegible]	CSS
Amanda Donovan	YTS
Chris McClure	BP

09-21-201

VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

April 05, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Ed Finch	BP
Starlin Scott Robbins	DMH/DD/SAS
Edgar Starnes	NCDST

VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

April 05, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
W. Denise Baker	NC DHHS/DSAS
NICHOLE KAELIN	NAMI NC
Ann Rodriguez	NC Council of Comm Programs
Nique William	NCCA
Krian Mcnaid	WCM
JOE LANIER	TSS
[illegible]	MVA
[illegible]	NA
Jak Sipe	NCFR
Adam Pridemore	NCABSA
Kelly Kirkpatrick	DP
MOLLA TYSON	CHP
MATT GLADOWSKI	SHP
SAM WATTS	NC DST
[illegible]	NCAE
Kelly Vogel	DLPCC
[illegible]	[illegible]

09-21-201

Senate Committee on Health Care
Thursday, April 6, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 6, 2017, in Room 643 of the Legislative Office Building. Fifteen members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by recognizing the pages–Wynter Mathis of Concord and Zachery Smith of Bailey, and the Sergeants-at-Arms–Terry Barnhardt, Billy Fritscher, and Charles Marsalis.

Senator Hise recognized Senator J. Davis to present SB 74–Update Rabies Control Laws. Senator J. Davis sent forward an amendment to his bill and explained it. Senator Tucker moved for adoption of the amendment. The motion passed. Senator Foushee moved for a favorable report to the amended bill, rolled into a PCS. The motion passed.

Senator Hise then recognized Senator Tillman to present SB 104–Require Criminal BGC/Pharmacist Licensure. Sen. Tucker moved for a favorable report to the bill. The motion passed.

Senator Krawiec was recognized to present the PCS, adopted by the committee on April 5, 2017, for SB–218 State Health Plan Administrative Changes.-AB. Senator Tarte moved for a favorable report of the PCS. The motion passed.

The meeting adjourned at 10:15 AM.

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Senate Committee on Health Care
Thursday, April 6, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Senator Ralph Hise, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 74	Update Rabies Control Laws.	Senator J. Davis
SB 104	Require Criminal BGC/Pharmacist Licensure.	Senator Tillman
SB 218	State Health Plan Administrative Changes.-AB	Senator Krawiec Senator Hise Senator Pate

Adjournment

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Thursday	April 6, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 74	Update Rabies Control Laws.	Senator J. Davis
SB 104	Require Criminal BGC/Pharmacist Licensure.	Senator Tillman
SB 218	State Health Plan Administrative Changes.-AB	Senator Krawiec Senator Hise Senator Pate

SB 218 - PCS will be heard on Wednesday and voted on Thursday.

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

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 06, 2017

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

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

SB **74** Update Rabies Control Laws.

Draft Number:	S74-PCS45403-BC-10
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Jim Davis will handle SB 74

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 74

Short Title:	Update Rabies Control Laws.	(Public)
Sponsors:	Senator J. Davis (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate	

February 15, 2017

A BILL TO BE ENTITLED

AN ACT IMPLEMENTING THE RECOMMENDATIONS AND GUIDELINES OF THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS REGARDING THE MANAGEMENT OF DOGS, CATS, AND FERRETS EXPOSED TO RABIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-197 reads as rewritten:

"§ **130A-197.** ~~**Infected animals to be destroyed; protection of vaccinated animals.**~~**Management of dogs, cats, and ferrets exposed to rabies.**

When the local health director reasonably suspects that an animal required to be vaccinated under this Part has been exposed to the saliva or nervous tissue of a proven rabid animal or animal reasonably suspected of having rabies that is not available for laboratory diagnosis, the animal shall be considered to have been exposed to rabies. ~~An animal exposed to rabies shall be destroyed immediately by its owner, the county Animal Control Officer or a peace officer unless the animal has been vaccinated against rabies in accordance with this Part and the rules of the Commission more than 28 days prior to being exposed, and is given a booster dose of rabies vaccine within five days of the exposure. As an alternative to destruction, the animal may be quarantined at a facility approved by the local health director for a period up to six months, and under reasonable conditions imposed by the local health director.~~The recommendations and guidelines specified by the National Association of State Public Health Veterinarians in the most current edition of the Compendium of Animal Rabies Prevention and Control shall be the required control measures."

SECTION 2. This act becomes effective October 1, 2017.

SENATE BILL 74:
Update Rabies Control Laws.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 4, 2017
Introduced by:	Sen. J. Davis	**Prepared by:**	Jason Moran-Bates
Analysis of:	First Edition		Committee Co-Counsel

OVERVIEW: Senate Bill 74 would require local health directors to use the guidelines issued by the National Association of State Public Health Veterinarians when deciding the proper control measures for a dog, cat, or ferret that has been exposed to rabies.

CURRENT LAW: Under current law, an unvaccinated dog, cat, or ferret exposed to rabies must be either euthanized or quarantined for six months. Vaccinated pets exposed to rabies must be given a booster shot.

BILL ANALYSIS: Senate Bill 74 would require local health directors to follow the most current guidelines issued by the National Association of State Public Health Veterinarians when determining the proper control measures for a dog, cat, or ferret exposed to rabies.

The most recent guidelines, issued March 1, 2016, state the proper control measures are:

- Animals with a current vaccine and animals that are overdue for a vaccine, but have documentation of previous vaccinations, should receive veterinary care, a rabies booster shot, and be kept under their owner's observation for 45 days.
- Unvaccinated animals should be euthanized; however, if the owner refuses to do so, they should receive immediate veterinary care and a rabies shot. Dogs and cats must be quarantined for four months, and ferrets must be quarantined for six months.
- Animals that are overdue for a vaccination and do not have any documentation of previous vaccinations can be treated as unvaccinated or undergo a prospective serological monitoring protocol to determine if the animal is demonstrating an adequate immune response

EFFECTIVE DATE: This bill would be effective October 1, 2017.

Karen Cochrane-Brown
Director

S74-SMBC-22 E1 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 74

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

S74-ABC-8 [v.1]

Amends Title [NO]
First Edition

Date April 6 ,2017

Senator J. Davis

moves to amend the bill on page 1, line 19, by rewriting the line to read:
"~~conditions imposed by the local health director.~~The recommendations and guidelines for rabies post exposure management specified by"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 06, 2017

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

FAVORABLE

SB **104** Require Criminal BGC/Pharmacist Licensure.

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

TOTAL REPORTED: 1

Senator Jerry W. Tillman will handle SB 104

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 104

Short Title:	Require Criminal BGC/Pharmacist Licensure.	(Public)
Sponsors:	Senators Tillman (Primary Sponsor); and Rabin.	
Referred to:	Rules and Operations of the Senate	

February 20, 2017

A BILL TO BE ENTITLED

AN ACT REQUIRING CRIMINAL BACKGROUND CHECKS FOR APPLICANTS FOR PHARMACIST LICENSURE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.15 reads as rewritten:

"**§ 90-85.15. ~~Application and examination~~Application, qualifications, and criminal record check for licensure as a pharmacist; prerequisites.**

(a) ~~Any person who desires to be licensed~~Each applicant for licensure under this Article as a pharmacist shall file an application with the Executive Director on the form furnished by the Board, verified under oath, setting forth ~~the~~all of the following:

(1) The applicant's ~~name, age, the~~name.

(2) The applicant's age.

(3) The place at which and the time that ~~he~~ the applicant has spent in the study of ~~pharmacy, and his~~ pharmacy.

(4) The applicant's experience in compounding and dispensing prescriptions under the supervision of a pharmacist.

~~The applicant shall also appear at a time and place designated by the Board and submit to an examination as to his qualifications for being licensed. The applicant must demonstrate to the Board his physical and mental competency to practice pharmacy.~~

(b) ~~On or after July 1, 1982, all applicants shall have received~~ The Board shall license an applicant to practice pharmacy if, in addition to completing an application as specified in subsections (a) of this section, the applicant meets all of the following qualifications:

(1) Holds an undergraduate degree from a school of pharmacy approved by the Board. ~~Applicants shall be required to have had~~

(2) Has had up to one year of experience, approved by the Board, under the supervision of a ~~pharmacist and shall pass~~pharmacist.

(3) Has passed the required examination offered by the Board. ~~Upon completing these requirements and upon paying the required fee, the applicant shall be licensed.~~

(4) Has appeared at a time and place designated by the Board and submitted to an examination as to the applicant's qualifications for being licensed. The applicant must demonstrate to the Board the physical and mental competency to practice pharmacy.

(c) ~~The Department of Public Safety may provide a criminal record check to the Board for a person who has applied for a license through the Board. The Board shall provide to the Department of Public Safety, along with the request, the fingerprints of the applicant, any~~

~~additional information required by the Department of Public Safety, and a form signed by the applicant consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Board shall keep all information pursuant to this subsection privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes.~~

~~The Department of Public Safety may charge each applicant a fee for conducting the checks of criminal history records authorized by this subsection.~~ The Board shall require each applicant to provide the Board with a criminal record report. All applicants shall obtain criminal record reports from one or more reporting services designated by the Board to provide criminal record reports. The Board shall keep all information obtained pursuant to this subsection privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes. Applicants are required to pay the designated reporting service for the cost of these reports."

SECTION 2. This act becomes effective January 1, 2018.

SENATE BILL 104:
Require Criminal BGC/Pharmacist Licensure.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 6, 2017
Introduced by:	Sen. Tillman	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 104 would make a number of technical changes to G.S. 90-85.15, which governs applications and requirements for licensure as a pharmacist, and mandate that the Board of Pharmacy require applicants for a pharmacy license to provide the Board with a criminal history report, at the applicant's expense, from a reporting service designated by the Board.***

CURRENT LAW: G.S. 90-85.15(c) allows the Department of Public Safety (DPS) to provide a criminal record check to the Board of Pharmacy for applicants for a pharmacy license. Currently, the Board is not required to request a background check, but if it does, it must submit a request that includes the fingerprints of the applicant and any additional information required by DPS. DPS then must send the applicant's fingerprints to the State and Federal Bureaus of Investigation for criminal history checks. The Board must keep any information pursuant to this law privileged and confidential, in accordance with applicable State law and the Board may charge each applicant a fee for conducting the criminal history check.

BILL ANALYSIS: Senate Bill 104 would make a number of technical changes to G.S. 90-85.15 and mandate that the Board of Pharmacy require applicants for a pharmacy license to provide the Board with a criminal record report from a reporting system that would be designated by the Board. Information from these reports would remain privileged and confidential in accordance with State law and federal guidelines, and applicants would be required to pay the designated reporting service for the cost of the report.

EFFECTIVE DATE: This act would become effective January 1, 2018.

Karen Cochrane-Brown
Director

S104-SMTY-19-E1-V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 06, 2017

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

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

SB **218** State Health Plan Administrative Changes.-AB

Draft Number:	S218-PCS35291-BC-9
Sequential Referral:	Appropriations on Pensions, Compensation, and Benefits
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle SB 218

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S D

SENATE BILL 218
PROPOSED COMMITTEE SUBSTITUTE S218-CSBC-9 [v.3]
03/29/2017 05:55:34 PM

Short Title: State Health Plan Administrative Changes.-AB (Public)

Sponsors:

Referred to:

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND ADMINISTRATIVE CHANGES TO THE LAWS RELATING TO THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.44(a) reads as rewritten:

"**§ 135-48.44. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

...

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact regarding eligibility or enrollment information or in a claim for reimbursement of medical services under the Plan. The State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the State Treasurer to make an exception as allowed for under this subdivision.

...."

SECTION 2. G.S. 135-48.40(c)(2) reads as rewritten:

"(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the ~~State.~~State unless prohibited by law. The total premium is the sum of the Plan's total employer premium contribution rate plus the employee or retiree's contribution for individual and dependent coverage."

SECTION 3.(a) G.S. 135-48.42(a) reads as rewritten:

"(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially

contributory or other contributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees ~~having coverage type (2) or (3), as outlined in G.S. 135-48.43(d)~~ shall be ~~automatically~~ covered at the time of birth ~~without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions~~ so long as the ~~claims processor~~ Plan receives notification within 30 days of the date of ~~birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that~~ birth and the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born."

SECTION 3.(b) This section becomes effective October 1, 2017, and applies to children born to covered employees on or after that date.

SECTION 4. G.S. 135-48.5(a) reads as rewritten:

"(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used ~~first,~~ in the following order:

(1) First, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented ~~claims, second,~~ claims.

(2) Second, up to fifty percent (50%) of any unencumbered balance remaining after providing for incurred but unpresented claims may be set aside by the State Treasurer, subject to approval by the Board of Trustees, to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits.

(3) Third, to reduce the premiums required in providing the benefits of the health benefits ~~programs, and third~~ programs.

(4) Fourth, to improve the plan, as may be provided by the ~~General Assembly.~~State Treasurer, subject to approval by the Board of Trustees.

The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein. The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3."

SECTION 5. G.S. 135-48.22 is amended by adding a new subdivision to read:

"(7) Approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a) and G.S. 135-48.30(a)(18)."

SECTION 6. G.S. 135-48.30(a) is amended by adding a new subdivision to read:

"(18) Set aside funds from the Public Employee Health Benefit Fund to reduce the State unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a), subject to approval by the Board of Trustees."

SECTION 7. G.S. 135-48.20 is amended by adding a new subsection to read:

"(n) Immunity. – Except to the extent provided under Article 31A of Chapter 143 of the General Statutes and to the extent of insurance coverage purchased pursuant to G.S. 58-32-15, a person serving on the Board of Trustees shall be immune individually from civil liability for monetary damages for any act, or failure to act, arising out of that service, except where any of the following apply:

(1) The person was not acting within the scope of that person's official duties.

(2) The person was not acting in good faith.

(3) The person committed gross negligence or willful or wanton misconduct that resulted in damages or injury.

(4) The person derived an improper personal financial benefit, either directly or indirectly, from the transaction.

(5) The person incurred the liability from the operation of a motor vehicle."

SECTION 8. G.S. 135-48.1 reads as rewritten:

"**§ 135-48.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

(1) Authorized representatives who are assisting the State Health Plan Division staff. – Staff of the Department of the State Treasurer, staff of the Department of Justice, or persons providing internal auditing assistance required under G.S. 143-746(b).

(1a) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

…."

SECTION 9. Part 1 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-48.16. Fraud detection and audit programs.**

(a) Access to Persons and Records. – In the course of conducting an investigation or a audit under G.S. 135-48.30(a)(9), the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall have ready access to the following:

(1) Persons, books, records, reports, vouchers, correspondence, files, personnel files, investments, and any other documentation of any employing unit. The Plan shall have the authority to both examine and make copies of the information described in this subdivision The review of State tax returns shall be limited to matters of official business, and the Plan's report shall not violate the confidentiality provisions of the tax laws.

(2) Persons, records, papers, reports, vouchers, correspondence, books, and any other documentation that is in the possession of any individual, private corporation, institution, association, board, or other organization that pertain to any benefits received, disbursed, or otherwise handled pursuant to a grant or contract from the federal government, the State, or its political subdivisions. Providers of social and medical services to a beneficiary shall make copies of records they maintain for services provided to the beneficiary.

(b) Records of Providers of Social and Medical Services. – Providers of social and medical services who provide ready access to the Plan under subdivision (2) of subsection (a)

of this section shall make copies of records they maintain for services provided to a beneficiary available to the Plan or to the authorized representatives who are assisting the State Health Plan Division staff. The Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall request records in writing by providing the name of each beneficiary from whom records are sought, the purpose of the request, the authority for the request, and a reasonable period of time for the production of record copies by the provider. A provider may charge, and the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall, in accordance with G.S. 90-411, pay a reasonable fee to the provider for copies of the records provided.

(c) Fraud Detection and Audit Reports and Work Papers. – The Plan shall maintain for 10 years a complete file of all compliance investigative reports, fraud investigative reports, and reports of other examinations, investigations, surveys, and reviews issued under the Plan's authority under G.S. 135-48.30(a)(9). Fraud or compliance investigation work papers and other evidence or related supportive material directly pertaining to the work of the State Health Plan Division of the Department of State Treasurer shall be retained according to an agreement between the Plan and State Archives. To promote intergovernmental cooperation and avoid unnecessary duplication of fraud investigative effort, and notwithstanding local unit personnel policies to the contrary, pertinent work papers and other supportive material relating to issued fraud or compliance investigation reports may be, at the discretion of the Executive Administrator of the Plan, and unless otherwise prohibited by law, made available for inspection by duly authorized representatives of the State and federal government who desire access to, and inspection of, such records in connection with some matter officially before them, including criminal investigations. Except as provided in this section, or upon an order issued in Wake County Superior Court upon 10 days' notice and hearing finding that access is necessary to a proper administration of justice, fraud investigation work papers and related supportive material shall be kept confidential, including any information developed as a part of the investigation."

SECTION 10. G.S. 105-259(b) is amending by adding a new subdivision to read:

"(39a) To furnish the Department of State Treasurer with information it requests related to an investigation or audit under G.S. 135-6(q), 135-48.16, or 128-28(r)."

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 218*

Short Title:	State Health Plan Administrative Changes.-AB	(Public)
Sponsors:	Senators Krawiec, Hise, and Pate (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND ADMINISTRATIVE CHANGES TO THE LAWS RELATING TO THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.44(a) reads as rewritten:

"**§ 135-48.44. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

...

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact regarding eligibility or enrollment information or in a claim for reimbursement of medical services under the Plan. The State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the State Treasurer to make an exception as allowed for under this subdivision.

...."

SECTION 2. G.S. 135-48.40(c)(2) reads as rewritten:

"(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the ~~State.~~State unless prohibited by law. The total premium is the sum of the Plan's total employer premium contribution rate plus the employee or retiree's contribution for individual and dependent coverage."

SECTION 3.(a) G.S. 135-48.42(a) reads as rewritten:

"(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory or other contributory basis. Coverage may become effective on the first day of the month following date of

entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees ~~having coverage type (2) or (3), as outlined in G.S. 135-48.43(d)~~ shall be ~~automatically~~ covered at the time of birth ~~without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions~~ so long as the ~~claims processor~~ Plan receives notification within 30 days of the date of ~~birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that~~ birth and the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born."

SECTION 3.(b) This section becomes effective October 1, 2017, and applies to children born to covered employees on or after that date.

SECTION 4. G.S. 135-48.5(a) reads as rewritten:

"(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used ~~first,~~ in the following order:

(1) First, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented ~~claims, second,~~ claims.

(2) Second, up to fifty percent (50%) of any unencumbered balance remaining after providing for incurred but unpresented claims may be set aside by the State Treasurer, subject to approval by the Board of Trustees, to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits.

(3) Third, to reduce the premiums required in providing the benefits of the health benefits ~~programs, and third~~ programs.

(4) Fourth, to improve the plan, as may be provided by the ~~General Assembly.~~State Treasurer, subject to approval by the Board of Trustees.

The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein. The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3."

SECTION 5. G.S. 135-48.22 is amended by adding a new subdivision to read:

"(7) Approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a) and G.S. 135-48.30(a)(18)."

SECTION 6. G.S. 135-48.30(a) is amended by adding a new subdivision to read:

"(18) Set aside funds from the Public Employee Health Benefit Fund to reduce the State unfunded actuarial accrued liability for post-employment retiree health

benefits as provided in G.S. 135-48.5(a), subject to approval by the Board of Trustees."

SECTION 7. G.S. 135-48.20 is amended by adding a new subsection to read:

"(n) Immunity. – Except to the extent provided under Article 31A of Chapter 143 of the General Statutes and to the extent of insurance coverage purchased pursuant to G.S. 58-32-15, a person serving on the Board of Trustees shall be immune individually from civil liability for monetary damages for any act, or failure to act, arising out of that service, except where any of the following apply:

(1) The person was not acting within the scope of that person's official duties.

(2) The person was not acting in good faith.

(3) The person committed gross negligence or willful or wanton misconduct that resulted in damages or injury.

(4) The person derived an improper personal financial benefit, either directly or indirectly, from the transaction.

(5) The person incurred the liability from the operation of a motor vehicle."

SECTION 8. This act is effective when it becomes law.

SENATE BILL 218:
State Health Plan Administrative Changes.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations on Pensions, Compensation, and Benefits. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 29, 2017
Introduced by:	Sens. Krawiec, Hise, Pate	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	PCS to First Edition S218-CSBC-9		

OVERVIEW: Senate Bill 218 would make administrative changes to statutes governing the North Carolina State Health Plan for Teachers and State Employees (Plan) that: 1) allow revocation of coverage for misrepresentations made by covered individuals; 2) pertain to the premium split between the state and certain General Assembly retirees; 3) provide coverage to children newly born to existing covered employees; 4) prioritize the order in which excess funds in the Public Employee Health Benefit Fund are used; 5) grant powers to the Board of Trustees and State Treasurer pertaining to the unfunded actuarial liability; and 6) provide members of the Board of Trustees with immunity from civil liability for most actions taken in their official capacity.

[As introduced, this bill was identical to H299, as introduced by Reps. Dobson, Corbin, Clampitt, Henson, which is currently in House Insurance.]

CURRENT LAW: When appropriate, the current law is in italics.

BILL ANALYSIS:

Section 1 would amend G.S. 135-48.44(a)(6) to clarify that an individual would lose coverage under the plan on the last day of the month the individual is found to have made a false representation of a material fact regarding eligibility or enrollment information.

Currently, individuals lose coverage only if they make false representations of material facts in a claim for reimbursement.

Section 2 would amend G.S. 135-48.40(c)(2) pertaining to one-half contributory coverage to clarify that General Assembly members and employees with 10 but less than 20 years of retirement service credit will have the State pay 50% of the balance toward their employer premiums, and the members and employees shall pay the balance of the total premium unless prohibited by law. Section 2 also amends G.S. 135-48.40(c)(2) to define "total premium" as the sum of the Plan's employer contribution rate and the employee or retiree's contribution rate.

Current law does not include the "unless prohibited by law" exception to the premium split or define the term "total premium."

Karen Cochrane-Brown
Director

S218-SMBC-20 CSBC-9 -V-2

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 3 would amend G.S. 135-48.42(a) pertaining to enrollment to clarify that children born to covered employees will be covered from birth so long as the participants notify the Plan within 30 days of birth and pay premiums retroactive to the first day of the month in which the child was born.

Section 4 would amend G.S. 135-48.5(a), which creates two health benefit trust funds, the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund, to clarify the order for using funds in the Public Employee Health Benefit Fund that are in excess of the amount needed to pay benefit and administrative costs. The excess funds shall be used in the following order:

- First, to establish a reserve for incurred but unpresented claims.
- Second, to be set aside to reduce the Plan's unfunded actuarial accrued liability for post-employment retiree health benefits. Any amount set aside must be approved by the Board of Trustees and limited to no more than 50% of the excess funds in the Public Employee Health Benefit Fund after establishing a reserve for incurred but unpresented claims.
- Third, to reduce the premiums required by the Plan.
- Fourth, to improve the Plan as provided by the State Treasurer, subject to approval by the Board of Trustees.

Currently there is no provision to use the excess funds to be set aside to reduce unfunded actuarial accrued liability for post-employment retiree health benefits, and the General Assembly, not the State Treasurer, has the authority to use finds to improve the Plan

Section 5 would amend G.S. 135-48.22, pertaining to the powers and duties of the trustees, to include the ability to approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits in the powers delegated to the Board of Trustees.

Section 6 would amend G.S.135-48.30(a), which outlies the powers and duties of the State Treasurer to provide that the State Treasurer the power to set aside funds from the Plan to reduce the Plan's unfunded actuarial accrued liability for post-employment retiree health benefits.

Section 7 would amend G.S. 135-48.20, which established the Board of Trustees to add a new subsection making individual members of the Board of Trustees immune from civil liability for actions taken in their official capacity except when:

- The member was not acting within the scope of the member's duties.
- The member was not acting in good faith.
- The member committed gross negligence or willful or wonton misconduct.
- The member derived an improper personal financial benefit from a transaction.
- The member incurred liability from the operation of a motor vehicle.

Section 8 would amend the definitions for the Plan in G.S. 135-48.1 to add a definition for "Authorized representatives who are assisting the State Health Plan Division staff." The definition used is the same as the one in the Local Governmental Employees' Retirement System (LGERS) and Teachers' and State Employees' Retirement System (TSERS) statutes.

Section 9 would add several new provisions to the Plan related to fraud detection and audit programs.

The first provision, substantially similar to those in LGERS and TSERS, would allow the Plan or its representatives to have access to people, books, records, reports, vouchers, correspondence, files, and investments of any employing unit, and the authority to inspect and make copies of that information.

The Plan or its representatives would also have access to people, records, papers, reports, vouchers, correspondence, and books in the possession of any person or organization that pertain to benefits handled pursuant to a grant or contract with the federal government, the State, or any political subdivision of the State.

Providers of social and medical services who provide access to the Plan must make copies of records maintained for services provided to beneficiaries and provide those copies to the Plan or its representatives when the Plan requests the documentation in writing. Requests must state the purpose and authority for the request and allow a reasonable time to produce the documents. Similar provisions are found in LGERS and TSERS.

Section 9 would also establish a records retention policy, similar to the LGERS and TSERS policies. The Plan would be required to maintain complete files of investigative reports for ten years, with those files being retained according to an agreement between the Plan and the State Archives. The files must be kept confidential; however, at the discretion of the Executive Administrator of the Plan the records may be made available to a representative of the State or federal government in connection with an official matter or criminal investigation. The records may also be disclosed if an order requiring disclosure is issued in Wake County Superior Court.

Section 10 would amend G.S. 105-259(b), pertaining to the disclosure of tax records, to allow State employees who have access to tax information to disclose information requested by the State Treasurer in connection with an investigation under G.S. 135-6(q), G.S. 135-48.16, or G.S. 128.28(r).

EFFECTIVE DATE: Section 3 would be effective October 1, 2017, and apply to children born to covered employees on or after that date. The remainder of bill would become effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2017

Legislative Actuarial Note
Health Benefits

BILL NUMBER: Senate Bill 218 (First Edition)

SHORT TITLE: State Health Plan Administrative Changes.-AB

SPONSOR(S): Senators Krawiec, Hise, and Pate

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

Section 1: Amends G.S. 135-48.44(a) to allow the Plan to terminate coverage when an individual knowingly and willfully provides false information during the enrollment process. Currently, the Plan can terminate coverage when an individual provides false information related to a claim.

Section 2: Amends G.S. 135-48.40(c)(2) to clarify that the retiree's premium for one-half contributory coverage is half of the employer contribution established by the General Assembly plus the employee contribution.

Section 3: Amends G.S. 135-48.42(a) to require members to enroll newborns they wish to cover within 30 days of birth. Currently, additional children born to a member who has elected employee-child or family coverage are automatically covered.

Sections 4-6: Allow the State Treasurer, subject to approval by the Board of Trustees, to set aside up to 50% of any unencumbered balance to reduce the State's unfunded accrued liability for retiree medical benefits.

Section 7: Provides limited civil immunity to members of the Board of Trustees.

EFFECTIVE DATE: Section 3 becomes effective October 1, 2017 and applies to children born on or after that date. The remainder of the bill is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

The Segal Company, the actuary for the Plan, estimates that the bill will have negligible financial impact on the Plan. However, The Segal Company notes that if funds are set aside under Sections 4-6, then they may need to be reimbursed through higher premium contributions in future years.

Hartman & Associates, the actuary for the General Assembly, also estimates that Sections 1-3 and 7 will not have a material impact on the Plan. Hartman & Associates notes that it is likely that any amount set

aside under Sections 4-6 would increase the magnitude of future premium increases or benefit reductions, although we do not know the likelihood or amount of any transfers that may be made.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments and charter schools may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

The State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement, with the exception of many Medicare-eligible retirees who are in fully-insured Medicare Advantage plans. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who participate in a plan with a non-zero premium or who elect dependent coverage. Benefit and premium changes are typically effective at January 1. The Plan's PPO benefit design includes three alternative benefit levels listed below:

1) The "Traditional" 70/30 plan that offers higher out-of pocket requirements in return for lower employee and retiree premiums and only one wellness activity,

2) The "Enhanced" 80/20 plan that offers lower out-of-pocket requirements with higher employee and retiree premiums, which can be lowered by completing three wellness activities, and

3) The Consumer-Directed Health Plan (CDHP) that applies deductibles and co-insurance to all services and offers lower employee and retiree premiums if one completes wellness activities

Medicare-eligible retirees are offered three alternative plans:

1) The "Traditional" 70/30 plan as coverage secondary to Medicare for medical services plus a pharmacy benefit plan,

2) "Base" Medicare Advantage Prescription Drug Plan (MA-PDP) from United Healthcare, that is actuarially equivalent to the "Enhanced" 80/20 Plan and applies in-network out-of-pocket requirements at out-of-network providers

3) "Enhanced" MA-PDP, identical to the "Base" MA-PDP, except with lower co-pays and higher retiree premiums

The following tables provide a summary of the most common monthly premium rates for the Plan in 2017:

Active Employees and Non-Medicare Retirees (if Fully Subsidized)

	Employer Share	Employee/Retiree Share	
		Complete All Wellness Activities *	Complete No Wellness Activities
Traditional 70/30 Plan	$479.48	$0.00	$40.00
Enhanced 80/20 Plan	$479.48	$15.04	$105.04
Consumer-Directed Health Plan (85/15)	$479.48	$0.00	$80.00

* Members receive credits for each activity. We have shown all or none for simplicity.

Medicare Retirees (if Fully Subsidized)

Medicare Advantage Plans

	Employer Share	Employee/Retiree Share
MA-PDP Base Plan	$372.56	$0.00
MA-PDP Enhanced Plan	$372.56	$64.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$372.56	$0.00

Dependents (paid by employee/retiree in addition to premiums above)

	All Dependents are Non-Medicare			One or More Medicare Dependents		
	Traditional 70/30	Enhanced 80/20	CDHP 85/15	MA-PDP Base	MA-PDP Enhanced	Traditional 70/30
Employee/Retiree + Children	$218.14	$290.14	$196.32	$124.80	$188.80	$155.20
Employee/Retiree + Spouse	$562.10	$668.48	$505.90	$124.80	$188.80	$408.08
Employee/Retiree + Family	$598.70	$708.72	$538.82	$249.60	$377.60	$444.66

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2016-17, employers contribute 5.81% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $950 million.

Financial Condition

Projected Results for CY 2017 and CY 2018 – The following summarizes projected financial results for 2017 and 2018, based on financial experience through September 2016. The projection assumes a 7.0% annual claims growth trend for medical claims, an 8.5% trend for pharmacy claims, benefit provisions and member-paid premiums as currently adopted by the Board, and 3.5% premium increases in 2018.

	($ millions) Projected CY 2017	Projected CY 2018
Beginning Cash Balance	$945.7	$834.1
Receipts:		
Net Premium Collections	$3,264.8	$3,369.6
Medicare Subsidies	$16.5	$16.6
Investment Earnings	$7.2	$6.2
Total	$3,288.5	$3,392.4
Disbursements:		
Net Medical Claim Payment Expenses	$2,271.9	$2,374.3
Net Pharmacy Claim Payment Expenses	$706.9	$787.2
Medicare Advantage Premiums	$192.6	$255.4
Administration and Claims-Processing Expenses	$228.7	$219.6
Total	$3,400.1	$3,636.5
Net Operating Income (Loss)	($111.6)	($244.1)

Of the premiums paid in CY 2017, an estimated $2.1 billion is derived from General Fund sources and an estimated $0.1 billion is derived from Highway Fund sources.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, fraud detection, and other authorized actions by the State Treasurer, Executive Administrator, and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Medical claim costs are expected to increase at a rate of 7.0% annually and pharmacy claim costs are expected to increase at a rate of 8.5% annually according to assumptions adopted by the Board of Trustees. The active population is projected to decline by 1% per year and the retired population is projected to increase by 1% per year.

Enrollment as of January 1, 2017

I. No. of Participants	Traditional 70/30	Enhanced 80/20	Consumer Directed	Medicare Advantage	Total	Percent of Total
Actives						
Employees	125,378	163,187	21,119	-	309,684	43.3%
Dependents	75,032	73,137	21,903	-	170,072	23.8%
Sub-total	200,410	236,324	43,022	-	479,756	67.1%
Retired						
Employees	59,349	25,367	1,671	111,890	198,277	27.7%
Dependents	8,029	4,182	903	9,447	22,561	3.2%
Sub-total	67,378	29,549	2,574	121,337	220,838	30.9%
Other						
Employees	2,618	5,921	980	-	9,519	1.3%
Dependents	1,522	2,368	767	-	4,657	0.7%
Sub-total	4,140	8,289	1,747	-	14,176	2.0%
Total						
Employees	187,345	194,475	23,770	111,890	517,480	72.4%
Dependents	84,583	79,687	23,573	9,447	197,290	27.6%
Grand Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**	**100%**
Percent of Total	**38.0%**	**38.4%**	**6.6%**	**17.0%**	**100.0%**	

II. Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	144,962	154,308	12,663	102,443	414,376
Employee Child(ren)	25,805	26,363	5,739	179	58,086
Employee Spouse	6,105	5,106	1,533	9,268	22,012
Employee Family	10,473	8,698	3,835		23,006
Total	**187,345**	**194,475**	**23,770**	**111,890**	**517,480**

Percent Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	77.4%	79.3%	53.3%	91.6%	80.1%
Employee Child(ren)	13.8%	13.6%	24.1%	0.2%	11.2%
Employee Spouse	3.3%	2.6%	6.4%	8.3%	4.3%
Employee Family	5.6%	4.5%	16.1%	0.0%	4.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	159,441	178,330	26,685	80,445	444,901
Male	112,487	95,832	20,658	40,892	269,869
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	58.6%	65.0%	56.4%	66.3%	62.2%
Male	41.4%	35.0%	43.6%	33.7%	37.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	73,899	70,290	18,777	3	162,969
26 to 45	68,332	76,095	13,837	228	158,492
46 to 55	46,137	56,424	8,217	873	111,651
56 to 65	47,542	66,377	6,204	11,420	131,543
66 & Over	36,018	4,976	308	108,813	150,115
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	27.2%	25.6%	39.7%	0.0%	22.8%
26 to 45	25.1%	27.8%	29.2%	0.2%	22.2%
46 to 55	17.0%	20.6%	17.4%	0.7%	15.6%
56 to 65	17.5%	24.2%	13.1%	9.4%	18.4%
66 & Over	13.2%	1.8%	0.7%	89.7%	21.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	48,342	11,835	60,177
Medicare Eligible in Traditional 70/30	38,045	1,279	39,324
Medicare Eligible in Base Medicare Advantage Plans	93,707	6,871	100,578
Medicare Eligible in Enhanced Medicare Advantage Plans	18,183	2,576	20,759
Total	**198,277**	**22,561**	**220,838**

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	24.4%	52.5%	27.2%
Medicare Eligible in Traditional 70/30	19.2%	5.7%	17.8%
Medicare Eligible in Base Medicare Advantage Plans	47.3%	30.5%	45.5%
Medicare Eligible in Enhanced Medicare Advantage Plans	9.2%	11.4%	9.4%
Total	**100.0%**	**100.0%**	**100.0%**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	68,024	32,792	100,816
UNC System	52,910	34,217	87,127
Local Public Schools	168,892	91,264	260,156
Charter Schools (88 entities)	4,111	2,688	6,799
Local Community Colleges	15,747	9,111	24,858
Other			
Local Goverments (91 entities)	8,882	4,128	13,010
COBRA	637	529	1,166
Sub-total	319,203	174,729	493,932
Retirement System *	198,277	22,561	220,838
Total	**517,480**	**197,290**	**714,770**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	13.1%	16.6%	14.1%
UNC System	10.2%	17.3%	12.2%
Local Public Schools	32.6%	46.3%	36.4%
Charter Schools	0.8%	1.4%	1.0%
Local Community Colleges	3.0%	4.6%	3.5%
Other			
Local Goverments	1.7%	2.1%	1.8%
COBRA	0.1%	0.3%	0.2%
Sub-total	61.7%	88.6%	69.1%
Retirement System	38.3%	11.4%	30.9%
Total	**100.0%**	**100.0%**	**100.0%**

* Includes 6 employees and 6 dependents covered as firefighters, rescue squad workers, or National Guard members

SOURCES OF DATA:

The Segal Company; baseline financial projections updated through Q3 CY2016 with 3.52% employer and employee premium increase in 2018, no further increases in wellness premiums/credits; dated January 24, 2017. Filename "CY16 Q3 - New Baseline - S1 - No Credit Increase in 2018+.pdf"

-Actuarial Note, Hartman & Associates, "House Bill 299/Senate Bill 218: An Act Make Clarifying and Administrative Changes to the Laws Relating to the State Health Plan for Teachers and State Employees", March 14, 2017, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, Senate Bill 218, "State Health Plan Administrative Changes-AB", March 27, 2017, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: David Vanderweide

APPROVED BY:

Mark Trogdon, Director
Fiscal Research Division

DATE: March 27, 2017

Signed Copy Located in the NCGA Principal Clerk's Offices

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 6, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Rurian Mcnald	UNC
David Collins	SEANC
Flint Benson	SEANC
[illegible]	[illegible]
[illegible]	[illegible]
Robb Jansen	NCSBE
Courtney Hennig	CVS Health
[illegible]	[illegible]
Abigail Stoddard	Prime Therapeutics
[illegible]	[illegible]
Kasthik Adapa	Gillings School of Global PH, UNC
Michael Zickler	UNC
Alex [illegible]	UNC
Scobin Seong	UNC CH
Pam Silberman	UNC CH
[illegible]	[illegible]
[illegible]	MVA

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 6, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Jake Sipe	NCFPC
Caroline Miller	AMGA
Sarah Wolfe	NMC
Kay Castillo	NASW NC
Holly Watkins	DHHS
Gail Williams	DHHS
[illegible]	NCALHD
LT McCrimmon	DHHS
Patty Grabowski	SNP
Mona Moon	DST/SHP
Starnes	OST
Martha Babcock	PPNB
Jaye Petus	CSS
Amanda Donovan	KTS
[illegible]	

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 6, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Lindsay Smith	shadowing
Adam Shaw	NCHCFA
Sarah McQuinn	ICOAPC
Daniel VanLiere	VOANT HEALTH

09-21-201

Senate Committee on Health Care
Wednesday, April 19, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 19, 2017 in Room 643 of the Legislative Office Building. Twenty-seven members were present.

Senator Louis M. Pate, Jr. presided.

Senator Pate welcomed everyone and recognized the Senate Sergeants-at-Arms --- Terry Edmondson, Billy Fritscher, and Tom Burroughs.

Senator Randleman presented SB 168 Subsidy Recipients to Cooperate/Child Support. Senator Newton motioned for a favorable report, the bill received a favorable report, and SB 168 was re-referred to Senate Committee on Rules and Operations of the Senate.

Senator Krawiec spoke on SB 317 Hypertension Awareness Day. Senator Robinson motioned for a favorable report, the bill received a favorable report from the committee, and SB 317 was re-referred to Senate Committee on Rules and operations of the Senate.

Senator Barringer presented SB 594 Family/Child Protection & Accountability Act. Senator Robinson motioned for a favorable report, the bill received a favorable report, and SB 594 was referred to Senate Committee on Appropriations/Base Budget.

Senator Hise spoke on SB 368 Notice of Medicaid SPA Submissions. Senator Tarte motioned for a favorable report, the bill received a favorable report, and SB 368 was re-referred to Senate Committee on rules and Operations of the Senate.

Senator Krawiec presented SB 383 Behav. Health Crisis EMS Transports/Medicaid. No motion was made on the bill, and SB 383 was placed on the following day's agenda.

The meeting adjourned at 10:55 AM.

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

Sinclaire Owen
Sinclaire Owen, Committee Clerk

Principal Clerk ____
Reading Clerk ____

Corrected #2: SB 384 has been removed.

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	April 19, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 168	Subsidy Recipients to Cooperate/Child Support.	Senator Randleman
SB 316	Suicide Prevention/Awareness School Personnel. For discussion only.	Senator Krawiec Senator D. Davis Senator Pate
SB 317	Hypertension Awareness Day.	Senator Krawiec Senator Pate Senator Hise
SB 368	Notice of Medicaid SPA Submissions.	Senator Hise Senator Pate Senator Krawiec
SB 383	Behav. Health Crisis EMS Transports/Medicaid. For discussion only.	Senator Krawiec Senator Pate Senator Hise
SB 594	Family/Child Protection & Accountability Act.	Senator Barringer Senator Harrington Senator Tucker

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

Senate Committee on Health Care
Wednesday, April 19, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 168	Subsidy Recipients to Cooperate/Child Support.	Senator Randleman
SB 317	Hypertension Awareness Day.	Senator Krawiec Senator Pate Senator Hise
SB 368	Notice of Medicaid SPA Submissions.	Senator Hise Senator Pate Senator Krawiec
SB 594	Family/Child Protection & Accountability Act.	Senator Barringer Senator Harrington Senator Tucker
SB 316	Suicide Prevention/Awareness School Personnel. *For discussion only*	Senator Krawiec Senator D. Davis Senator Pate
SB 383	Behav. Health Crisis EMS Transports/Medicaid. *For discussion only*	Senator Krawiec Senator Pate Senator Hise

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, April 19, 2017

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

FAVORABLE

SB **168** Subsidy Recipients to Cooperate/Child Support.
- Draft Number: None
- Sequential Referral: Rules and Operations of the Senate
- Recommended Referral: None
- Long Title Amended: No

SB **317** Hypertension Awareness Day.
- Draft Number: None
- Sequential Referral: Rules and Operations of the Senate
- Recommended Referral: None
- Long Title Amended: No

SB **368** Notice of Medicaid SPA Submissions.
- Draft Number: None
- Sequential Referral: Rules and Operations of the Senate
- Recommended Referral: None
- Long Title Amended: No

SB **594** Family/Child Protection & Accountability Act.
- Draft Number: None
- Sequential Referral: Appropriations/Base Budget
- Recommended Referral: None
- Long Title Amended: No

TOTAL REPORTED: 4

Senator Shirley B. Randleman will handle SB 168
Senator Joyce Krawiec will handle SB 317
Senator Ralph Hise will handle SB 368
Senator Tamara Barringer will handle SB 594

SENATE BILL 168:
Subsidy Recipients to Cooperate/Child Support.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 19, 2017
Introduced by:	Sen. Randleman	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	First Edition		

OVERVIEW:

CURRENT LAW: S.L. 2015-51 required the Department of Health and Human Services, Division of Child Development and early Education (DCDEE) and the Division of Social Services (DSS) to 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.

BILL ANALYSIS: Senate Bill 168 would require the Department to implement the plan developed pursuant to S.L. 2015-51. Implementation of the plan would have to include, at a minimum, the components described in Section 1(a) of S.L. 2015-51, as well as any criteria DCDEE and DSS identified in its report on the plan as submitted to the Joint Legislative Oversight Committee on Health and Human Services dated February 1, 2016.

DCDEE and DSS would be required to report on the implementation of the plan to the Joint Legislative Oversight Committee on health and Human Services and the Fiscal Research Division no later than October 1, 2018.

EFFECTIVE DATE: This act would be effective when it becomes law.

Karen Cochrane-Brown
Director

S168-SMTY-28 E1 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

SENATE BILL 168

Short Title:	Subsidy Recipients to Cooperate/Child Support.	(Public)
Sponsors:	Senator Randleman (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate	

March 2, 2017

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION AND THE DIVISION OF SOCIAL SERVICES, TO IMPLEMENT THE PLAN REQUIRING CHILD CARE SUBSIDY PAYMENT RECIPIENTS TO COOPERATE WITH COUNTY CHILD SUPPORT SERVICES PROGRAMS AS A CONDITION OF RECEIVING CHILD CARE SUBSIDY PAYMENTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Beginning January 1, 2018, the Department of Health and Human Services, the Division of Child Development and Early Education (DCDEE) and the Division of Social Services (DSS), shall implement the plan developed pursuant to S.L. 2015-51 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 the county child support services program as a condition of receiving child care subsidy payments. DCDEE and DSS shall implement the plan, which shall include, at a minimum, the components described in Section 1(a) of S.L. 2015-51, as well as any criteria DCDEE and DSS identified in its report on the plan as submitted to the Joint Legislative Oversight Committee on Health and Human Services dated February 1, 2016.

SECTION 1.(b) The Division of Child Development and Early Education and the Division of Social Services shall report on the implementation of the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than October 1, 2018.

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

SENATE BILL 317:
Hypertension Awareness Day.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 19, 2017
Introduced by:	Sens. Krawiec, Pate, Hise	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 317 would designate the third Wednesday in May of each year as Hypertension/High Blood Pressure Awareness Day.***

[As introduced, this bill was identical to H411, as introduced by Reps. Carney, Murphy, Holley, Yarborough, which is currently in House Health.]

BILL ANALYSIS: Senate Bill 317 would add a new section to Chapter 130 of the General Statutes (Sundays, Holidays, and Special Days) to designate the third Wednesday in May of each year as Hypertension/High Blood Pressure Awareness Day in North Carolina.

EFFECTIVE DATE: This act would be effective when it becomes law.

Karen Cochrane-Brown
Director

S317-SMTY-29 F1 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 317*

Short Title:	Hypertension Awareness Day.	(Public)
Sponsors:	Senators Krawiec, Pate, Hise (Primary Sponsors); Smith-Ingram and Waddell.	
Referred to:	Rules and Operations of the Senate	

March 20, 2017

A BILL TO BE ENTITLED

AN ACT DESIGNATING THE THIRD WEDNESDAY IN MAY OF EACH YEAR AS HYPERTENSION/HIGH BLOOD PRESSURE AWARENESS DAY.

Whereas, the health of our citizens is the foundation for a caring and productive society; and our future rests with our ability to treat and ultimately to prevent a variety of illnesses including high blood pressure; and

Whereas, heart disease and stroke are the second and fourth leading causes of death in North Carolina; and high blood pressure, also known as hypertension, is a major and modifiable risk factor for heart disease and stroke and is a major contributor to adult disability; and

Whereas, in 2015, 35.2% of North Carolina adults recalled being told that they had hypertension; and

Whereas, current awareness and treatment for high blood pressure is not adequate; and

Whereas, more than two out of every three people who have a first heart attack also have high blood pressure, and three out of every four people who have a first stroke also have high blood pressure; and

Whereas, adequate medical treatments and proven preventive health strategies that include a low-salt diet with more fruits and vegetables are beneficial; and

Whereas, patients with high blood pressure who are treated early have a longer life expectancy; and

Whereas, education can help with early diagnosis, prevention, and better treatment; and

Whereas, the Justus-Warren Heart Disease and Stroke Prevention Task Force, the American Heart Association/American Stroke Association, and the North Carolina Academy of Family Physicians are organizations that have agreed to support Hypertension/High Blood Pressure Awareness Day, scheduled for the third Wednesday in May in 2017 and continuing in perpetuity; and these partners seek ways to improve the health of the citizens of North Carolina by improving prevention and treatment of high blood pressure through support of education, advocacy, and awareness; Now therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 103 of the General Statutes is amended by adding a new section to read:

"**§ 103-15. Hypertension/High Blood Pressure Awareness Day.**

The third Wednesday in May of each year is designated as Hypertension/High Blood Pressure Awareness Day in North Carolina."

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

SENATE BILL 594:
Family/Child Protection & Accountability Act.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 18, 2017
Introduced by:	Sens. Barringer, Harrington, Tucker	**Prepared by:**	Tawanda N. Foster Staff Attorney
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 594 does the following: 1) reforms the State child welfare system; 2) improves accountability and state oversight of the child welfare system; 3) requires the State to develop a plan for a regional system of social services departments; 4) establishes a child well-being transformation council to improve coordination, collaboration, and communication among child-serving agencies; 5) establishes a pilot program to help youth in substitute care obtain drivers licenses; 6)establishes a pilot program to authorize a waiver of the employment requirement for foster parents with children receiving intensive alternative family treatment; 7) reduces the time a parent has to appeal from a termination of parental rights order; and 8) reduces the time frame for foster care licensure approval.***

[As introduced, this bill was identical to H608, as introduced by Reps. Stevens, Lewis, Dollar, Jordan, which is currently in House Homelessness, Foster Care, and Dependency.]

BILL ANALYSIS:

PART I. REGIONAL SOCIAL SERVICES DEPARTMENTS; WORKING GROUP

Section 1.1 requires the Department of Health and Human Services (Department) to develop a plan to transition from a State-supervised, county-administered system to a State-supervised, regionally administered system by January 1, 2022.

- A preliminary plan must be submitted to the Joint Legislative Oversight Committee on Health and Human Services by January 15, 2019. A final plan must be submitted to this same committee by March 31, 2019.

Section 1.2 establishes a Social Services Regionalization Working Group (Working Group) to make recommendations to the Department regarding the preliminary plan for regionalization.

- The Working Group must submit an interim report to the Joint Legislative Oversight Committee on Health and Human Services by June 30, 2018. A final report must be submitted to this same committee by December 1, 2018.
- The UNC School of Government shall assist the working group.

Section 1.3 appropriates $48,400 from the General Fund to the School of Government for the 2017-2018 fiscal year and appropriates $25,700 for the 2018-2019 fiscal year for its role in assisting in the development of the regionalization plan.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 1.4 appropriates $38,039 from the General Fund to the Department for the 2017-2018 fiscal year and appropriates $16,303 for the 2018-2019 fiscal year for reimbursement costs associated with the duties of the Working Group.

Section 1.5 provides Sections 1.3 and 1.4 become effective July 1, 2017.

PART II. REFORMING STATE SUPERVISION AND ACCOUNTABILITY OF THE STATE'S CHILD WELFARE SYSTEM

Section 2.1 directs the Office of State Budget Management in consultation with the Department of Health and Human Services to develop and issue a request for proposal (RFP) by January 15, 2018 to contract with a third-party organization to evaluate the State's child welfare system, develop a plan for reforming the system, and provide ongoing evaluation and oversight of the implementation of the child welfare system reform.

- The third-party organization shall submit its preliminary report to the Joint Legislative Oversight Committee on Health and Human Services no later than 180 days after the contract is finalized. The organization must also submit bimonthly reports to the Committee beginning no later than September 15, 2019.
- The Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services no later than September 15, 2019 describing the progress made on implementation to date, implementation plans and time lines for the subsequent 24 months, and a summary of significant challenges encountered during implementation.

Section 2.2.(a) appropriates $3,100,000 in non-recurring funds from the General Fund to the Department of Health and Human Services, Division of Social Services for the 2018-2019 fiscal year to implement the child welfare system reform.

Section 2.2.(b) provides Section 2.2 becomes effective July 1, 2017.

PART III. LOCAL DSS; CORRECTIVE ACTION

Section 3.1 amends G.S. 108A-74 to require local departments to meet required standards in child welfare or they will be subject to corrective action.

- The Secretary will develop a standard set of develop a standard set of performance and outcome metrics for child welfare services. Departments of social services shall satisfy mandated performance requirements that are based on those metrics.
- If a department fails to meet the performance requirements for three consecutive months or five months within a consecutive 12-month period, the department shall enter into a joint corrective action plan within 60 working days. The joint corrective action plan may not exceed 18 months.
- If a department fails to successfully complete a corrective action plan the Secretary may temporarily assume all or part of the department's child welfare program administration.
- Also, this section revises definitions to remove the term "county" and add a definition for "child welfare program."

Section 3.2 provides Section 3.1 becomes effective six months after all 100 counties in the State have implemented the child welfare component to the North Carolina Families Accessing Services through Technology (NC FAST) system.

PART IV. CHILD WELL BEING TRANSFORMATION COUNCIL

Section 4.1 adds a new Article to Chapter 143 of the General Statues to establish the Child Well-Being Transformation Council (Council) to serve as a means for coordination, collaboration, and communication among agencies and organizations involved in providing public services to children.

- The Council will be located administratively in the General Assembly and will consist of 13 members serving staggered terms. The initial Council members shall be appointed on or after July 1, 2018, as follows:
    - Three members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.
    - Three members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.
    - Seven members shall be appointed by the Governor.
- The Council must submit a report to the 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, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by June 30 of each year.
- The Council is allowed to accept gifts or grants from other sources to support its administration.

Section 4.2.(a) appropriates $12,692 in non-recurring funds from the General Fund to the Legislative Services Commission for the 2018-2019 fiscal year for the purposes of assisting in establishing the Council.

Section 4.2.(b) provides Section 4.2 becomes effective July 1, 2017.

PART V. DRIVERS LICENSE PILOT PROJECT

Section 5.1 requires the Department of Health and Human Services, Division of Social Services to establish a two year pilot program that shall reimburse, on a first come, first served basis, youth and caregivers' costs associated with drivers license education, drivers license fees, insurance costs, and any other costs associated with obtaining a drivers license.

- The Division of Social Services shall report on the pilot project to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2018.

Section 5.2.(a) appropriates $75,000 for the 2017-2018 fiscal year and $75,000 for the 2018-2019 fiscal year to conduct the pilot project.

Section 5.2.(b) provides Section 5.2 becomes effective July 1, 2017.

PART VI. PILOT WAIVER FOR IAFT FOSTER PARENTS

Section 6 requires the Department of Health and Human Services, Division of Social Services (Division) to establish a pilot program that will allow the Division to waive the employment requirement for foster parents.

- LME/MCOs participating in the IAFT pilot waiver program must provide a report on the outcomes of the pilots, along with any recommendations, to the Division. The Division will then submit a report on the pilot waiver program to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018.

PART VII. TERMINATION OF PARENTAL RIGHTS/TIME FRAME FOR APPEALS

Section 7 amends G.S. 7B-1001(a)(5)b to reduce the time from 180 days to 65 days for parents to appeal a termination of parental rights order.

PART VIII. TIME FRAME FOR LICENSURE APPROVAL/FOSTER CARE

Section 8 amends G.S. 131D-10.3 to require the Department to grant or deny a license to provide foster care or therapeutic foster care within three months of the date of the application.

- Also directs the Department to further examine the existing time frames for processing foster care and therapeutic foster care applications and determine methods to further reduce the time frames for approving or denying applications for licensure.

EFFECTIVE DATE: Sections 1.3, 1.4, 2.2, 4.2 and 5.2 would become effective July 1, 2017. Section 3.1 would become effective six months after all 100 counties in the State have implemented the child welfare component to the North Carolina Families Accessing Services through Technology (NC FAST) system. Except as otherwise provided, this bill would become effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 594*

Short Title:	Family/Child Protection & Accountability Act.	(Public)
Sponsors:	Senators Barringer, Harrington, Tucker (Primary Sponsors); Alexander, Ballard, Blue, Cook, Dunn, Gunn, Krawiec, Lee, Newton, Sanderson, Smith-Ingram, Tarte, Van Duyn, and Waddell.	
Referred to:	Rules and Operations of the Senate	

April 5, 2017

A BILL TO BE ENTITLED

AN ACT TO REFORM THE CHILD WELFARE SYSTEM IN THIS STATE; IMPROVE ACCOUNTABILITY AND STATE OVERSIGHT OF THE CHILD WELFARE SYSTEM; REQUIRE THE STATE TO DEVELOP A PLAN FOR A REGIONAL SYSTEM OF SOCIAL SERVICES DEPARTMENTS; ESTABLISH A CHILD WELL-BEING TRANSFORMATION COUNCIL TO IMPROVE COORDINATION, COLLABORATION, AND COMMUNICATION AMONG CHILD-SERVING AGENCIES; ESTABLISH A PILOT PROGRAM TO HELP YOUTH IN SUBSTITUTE CARE OBTAIN DRIVERS LICENSES; ESTABLISH A PILOT PROGRAM TO AUTHORIZE A WAIVER OF THE EMPLOYMENT REQUIREMENT FOR FOSTER PARENTS OF CHILDREN RECEIVING INTENSIVE ALTERNATIVE FAMILY TREATMENT; REDUCE THE TIME FRAME A PARENT HAS TO APPEAL FROM A TERMINATION OF PARENTAL RIGHTS ORDER; AND REDUCE THE TIME FRAME FOR LICENSURE APPROVAL REGARDING FOSTER CARE.

Whereas, the children and families involved in North Carolina's child welfare system are among our most vulnerable children and most fragile families; and

Whereas, the recent federal Child and Family Services Review (CFSR) and the North Carolina Statewide Child Protective Services Evaluation of the State's Child Protective Services (CPS) program identified troubling gaps and flaws in North Carolina's child welfare system that are allowing too many of those vulnerable children and fragile families to fall through the cracks; and

Whereas, transforming the child welfare system to better ensure the safety, permanency, and well-being of children and families is the right thing to do; and

Whereas, county social services agencies are facing significant resource and administration challenges in areas other than child welfare, such as public assistance and adult services; and

Whereas, a recent audit by the North Carolina State Auditor of Medicaid eligibility determinations by county departments of social services concluded that most of the county departments reviewed in the audit did not consistently meet standards for timeliness and accuracy; and

Whereas, a recent report by the Program Evaluation Division reached similar conclusions regarding county administration of Medicaid eligibility determinations; and

Whereas, North Carolina's Aging Services Plan and a recent report on Alzheimer's and related dementias by the North Carolina Institute of Medicine emphasize the tremendous

growth of the aging population and anticipate relying heavily on social services agencies to support the needs of this population; and

Whereas, it has been challenging for the State to effectively supervise administration of complex social services programs in 100 counties and it would be more efficient and effective for the State to supervise fewer local agencies; and

Whereas, it is our charge to spend public dollars wisely and effectively on administration of public assistance; and

Whereas, for the aforementioned reasons, North Carolina requires a plan of action to systematically reform the child welfare system and reduce the number of departments of social services to allow for better supervision and administration of social services programs; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. REGIONAL SOCIAL SERVICES DEPARTMENTS; WORKING GROUP

SECTION 1.1. Transition to Regional Social Services Departments. – The Department of Health and Human Services (Department) shall develop a plan for regional organization, administration, and governance of the social services system in North Carolina. The plan shall recommend a system of public authorities that includes no more than 30 regions and is operational no later than January 1, 2022. The plan will have the effect of transforming North Carolina's State-supervised, county-administered system into a State-supervised, regionally administered system. It is essential that the plan reflect the interests of all stakeholders involved with the current system. The Department shall develop a preliminary plan and a final plan as follows:

(1) Preliminary plan. – The Department shall prepare a preliminary plan that incorporates recommendations submitted to the Department by the Social Services Regionalization Working Group created under Section 1.2 of this act. In developing the preliminary plan, the Department shall implement a process for soliciting stakeholder input on the plan. The Department shall submit the preliminary plan to the Joint Legislative Oversight Committee on Health and Human Services by January 15, 2019.

(2) Final plan. – The Department shall revise the preliminary plan to incorporate changes based on information it receives from stakeholders. The final plan shall include a proposed time line for completing the transition to a regional social services system by January 1, 2022. The Department shall submit the final plan to the Joint Legislative Oversight Committee on Health and Human Services (Committee) by March 31, 2019. If the Department fails to submit a final plan to the Committee by March 31, 2019, then the Committee shall proceed with developing its own plan for regionalization.

SECTION 1.2.(a) Social Services Regionalization Working Group. – The School of Government at the University of North Carolina at Chapel Hill (SOG) shall convene a Social Services Regionalization Working Group (Working Group) to make recommendations to the Department regarding the preliminary plan for regionalization.

SECTION 1.2.(b) Composition. – The Working Group shall consist of the following members:

(1) Three members of the Senate upon recommendation of the President Pro Tempore of the Senate, one of whom shall be designated as a cochair.

(2) Three members of the House of Representatives upon recommendation of the Speaker of the House of Representatives, one of whom shall be designated as a cochair.

(3) Three representatives from the Department of Health and Human Services upon recommendation of the Secretary of Health and Human Services, or the Secretary's designee.
(4) One designee of the Chief Justice of the North Carolina Supreme Court.
(5) Four county commissioners representing the North Carolina Association of County Commissioners, each of whom shall represent different regions of the State.
(6) Two representatives from the North Carolina Association of Directors of Social Services.
(7) One representative from the North Carolina Association of Social Services Attorneys.

SECTION 1.2.(c) Ad Hoc Subcommittees. – The cochairs may, at their discretion, establish ad hoc subcommittees involving experts and representatives of stakeholder organizations to provide information and offer recommendations related to their areas of expertise and interest. Experts and organizations may include:

(1) Social Services Commission.
(2) North Carolina Association of County Boards of Social Services.
(3) Guardian ad Litem program.
(4) Office of Indigent Defense Services.
(5) North Carolina Partnership for Children, Inc.
(6) Disability Rights of North Carolina.
(7) Benchmarks NC.
(8) North Carolina Association of Local Health Directors.
(9) North Carolina Council of Community Programs.
(10) North Carolina Emergency Management Association.
(11) North Carolina Child Support Council.
(12) North Carolina Pediatric Society.
(13) AARP North Carolina.
(14) County commissioners representing jurisdictions that have diverse geographic, socioeconomic, and demographic characteristics.
(15) Directors and administrators of consolidated human services agencies.
(16) Other experts or stakeholders identified by the cochairs.

SECTION 1.2.(d) Duties. – The Working Group shall develop recommendations for the regionalization plan required by Section 1.1 of this act. At a minimum, the recommendations shall:

(1) Focus on the need to improve service delivery, enhance the quality of services provided, increase efficiency and accuracy, and promote uniformity of service availability and delivery across the State.
(2) Specify the services a regional agency would be required and authorized to provide and the functions it would be required and authorized to perform.
(3) Identify factors to consider when establishing the size of the regions, including (i) the need to ensure that the size of the region allows the region to maintain a direct, local connection with the jurisdictions it serves and (ii) the cultural differences and similarities between regions.
(4) Propose a regional system that provides for centralized administrative operations that are geographically located in one county, but preserves a physical presence for delivery of social services in every county served by the region.
(5) Strive to align the new regions with both county borders and judicial districts in order to ensure seamless connections between child welfare, adult protective services, child support enforcement, and the judicial system.

(6) Consider the implications of making the regional agencies public authorities, as defined in G.S. 159-7(10), and identify policy and administrative issues that would need to be addressed in legislation when creating the authorities.

(7) Identify one or more options for maintaining county contributions to social services programs at appropriate levels to ensure adequate services are available throughout the region and each county in a region is financially accountable for the proportion of services provided in that county.

(8) Propose a governance structure for the regional agencies that, at a minimum, requires a governing board, outlines the process for appointing board members, and requires at least one county commissioner from each county within the region to serve on a governing board.

(9) Propose powers and duties of the governing board, which shall include the authority to hire and supervise the director of the regional agency.

(10) Consider the leadership needs for the regional agencies, including the minimum qualifications for the agency director, as well as the necessary powers and duties of the director.

(11) Propose safeguards to ensure that the regional agencies maintain effective working relationships with the other human services agencies and stakeholders serving the same counties.

(12) Consider the implications of having personnel of the regional agencies exempt from or subject to Chapter 126 of the General Statutes.

(13) Consider the implications of regionalization of social services for counties that have established consolidated human services agencies pursuant to G.S. 153A-77 and explore options for integrating regionalized administration into the framework of consolidated agencies, granting exemptions to regionalization for consolidated agencies, authorizing regional consolidated human services agencies, and reversing consolidations.

SECTION 1.2.(e) Report – The Working Group shall submit an interim report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) no later than June 30, 2018. After receiving the interim report, the Committee may terminate the Working Group if it concludes that the Working Group is not making sufficient progress. The Working Group shall submit a final report, including its recommendations in accordance with subsection (c) of this section, to the Committee and the Department of Health and Human Services by December 1, 2018.

SECTION 1.2.(f) Role of the School of Government. – The School of Government at the University of North Carolina at Chapel Hill shall assist the Working Group as follows:

(1) Convene and facilitate meetings.

(2) Provide necessary clerical and administrative support.

(3) Prepare the Working Group's preliminary and final reports.

(4) Provide technical assistance, as appropriate.

SECTION 1.3. SOG Funds. – There is appropriated from the General Fund to the School of Government at the University of North Carolina at Chapel Hill the sum of forty-eight thousand four hundred dollars ($48,400) for the 2017-2018 fiscal year and the sum of twenty-five thousand seven hundred dollars ($25,700) for the 2018-2019 fiscal year for its role in assisting in developing the regionalization plan under Section 1.2 of this act.

SECTION 1.4. Working Group Funds. – There is appropriated from the General Fund to the Department of Health and Human Services the sum of thirty-eight thousand thirty-nine dollars ($38,039) for the 2017-2018 fiscal year and the sum of sixteen thousand three hundred three dollars ($16,303) for the 2018-2019 fiscal year for reimbursement costs associated with duties of the Working Group.

SECTION 1.5. Sections 1.3 and 1.4 of this act become effective July 1, 2017.

PART II. REFORMING STATE SUPERVISION AND ACCOUNTABILITY OF THE STATE'S CHILD WELFARE SYSTEM

SECTION 2.1.(a) The Office of State Budget and Management, in consultation with the Department of Health and Human Services, shall develop and issue a request for proposal (RFP) no later than January 15, 2018, to contract with a third-party organization to evaluate the State's child welfare system, develop a plan for reforming the system in order to improve outcomes for children and enhance State supervision of local administration, and provide ongoing evaluation and oversight of the agency's implementation of child welfare reform. In developing the implementation plan, the organization shall engage the services of national technical advisors with broad expertise and experience in implementing large-scale, systemic child welfare reform. The organization, along with national technical advisors, shall undertake a comprehensive, diagnostic assessment of the State's child welfare system, including its points of contact with other child-serving State systems, and develop a plan for reforming the system to include, at a minimum, the following child welfare activities:

(1) Child Protective Services (CPS), including receiving reports and investigating allegations of child abuse, neglect, or dependency.

(2) Preventive and in-home services that provide struggling families with needed supports and treatment to prevent removal of the children from the home.

(3) Placement of children in foster care and other out-of-home settings.

(4) Services provided to children, youth, and parents involved with child welfare to achieve reunification of families.

(5) Efforts to achieve permanency for children either through reunification with family, legal guardianship or custody, or adoption.

(6) Provision of health care, mental health, and educational services to children and families involved with the child welfare system.

(7) Services provided to older youth in foster care and to those who have aged out of foster care.

SECTION 2.1.(b) In addition to the requirements under subsection (a) of this section, the child welfare reform plan shall propose critical changes, as needed, to the major structural components of the State's child welfare system, including each of the following:

(1) Visioning and an overarching strategic direction for the Department of Health and Human Services, Division of Social Services.

(2) Collection, analysis, and effective use of data.

(3) Leadership and governance at the State level.

(4) Changes necessary to ensure well-trained and adequately compensated staff to improve performance and reduce turnover.

(5) Practice and implementation, including:

a. Ensuring a statewide, trauma-informed, culturally competent, family-centered practice framework.

b. Incorporating more evidence-based practices, including evidence-informed prevention services designed to reduce the number of children entering foster care.

c. Specifying expectations regarding professional development, training, and performance standards.

d. Eliminating unnecessary barriers to licensing foster care and therapeutic foster care families to ensure an adequate supply of qualified families.

e. Improving provider and foster parent feedback loops. For purposes of this sub-subdivision, "feedback loops" refers to a situation in which a portion of the output of a situation is used for new input.
f. Performing time use and salary surveys for Division of Social Services staff.
g. Promoting relationship-building across agencies and providers.
h. Implementing family supports for adoptions, which includes (i) collecting data on the incidence of disrupted adoptions and unlawful transference of children in North Carolina, (ii) the outcomes for children and families associated with disrupted adoptions, and (iii) the provision of supports needed to assist families at risk of disruption in order to keep those families together.
i. Maintaining sibling groups, in accordance with the "Fostering Connections to Success and Increasing Adoptions Act of 2008."
j. Developing a statewide, standardized functional assessment to be used for case planning, service referrals, and to enhancing executive-level decision making around resource allocation and other system reform efforts.

(6) Consistent, standardized continuous quality improvement (CQI) at the State and county levels.

(7) Analysis and alignment of policies and procedures to support and accelerate system reform, focusing on sustainable change that will improve outcomes for children and families.

SECTION 2.1.(c) In developing the child welfare reform plan pursuant to this section, the organization shall do each of the following:

(1) Ensure the plan complies with the requirements of the federal Child and Family Services Review Program Improvement Plan effective January 1, 2017.

(2) Consult with the Social Service Regionalization Working Group on the development of the regionalization plan and offer recommendations appropriate to align the regionalization plan with the child welfare reform plan.

(3) Review the program for corrective action under G.S. 108A-74, as amended by Section 3.1 of this act, and offer any recommendations necessary to align the corrective action program with the child welfare reform plan.

SECTION 2.1.(d) The child welfare system reform effort described in this act shall also include the creation of a Child Welfare System Transparency and Wellness Dashboard (Dashboard) that will collect data from the North Carolina Families Accessing Services through Technology (NC FAST) system. The Dashboard shall serve as a report card and include regular reports of the components described under subsection (b) of this section and be continuously updated to allow for monitoring by State leadership, staff and families involved in the child welfare system, and the general public to ensure maximum accountability and transparency and the effective and efficient use of child welfare services and funds. Specifically, the Dashboard shall address the data issues highlighted in the Child and Family Services Review (CFSR) and the North Carolina Statewide Child Protective Services Evaluation of the State's Child Protective Services system dated March 1, 2016, to ensure the provision of accurate federal reporting and improved case management, continuous quality improvement (CQI), and overall improved outcomes for children and families. The Division of Social Services shall post data from a department of social services' report card on the Division's Web site, and the data shall be updated to ensure accurate reporting. For purposes of this section, the term "Dashboard"

means a standard set of performance and outcome metrics that indicate how effectively the child welfare system is working.

SECTION 2.1.(e) The following reporting and implementation requirements shall occur:

(1) The Office of State Budget and Management (OSBM) shall report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) upon hiring an organization to develop the child welfare reform plan pursuant to this section.

(2) OSBM shall include in the contract clear direction that time is of the essence and failure to perform within the required time line constitutes breach of contract. OSBM shall also include a provision in the contract authorizing it to terminate the contract without financial penalty to the State if OSBM, in consultation with the Committee, determines that progress on development of the child welfare reform plan is unsatisfactory.

(3) The organization shall submit a preliminary report to the Committee no later than 180 days after the contract is finalized. The preliminary report shall set forth the organization's vision for developing the child welfare reform plan. After that report is submitted, the organization shall submit bimonthly reports to the Committee on the progress of development and implementation of the child welfare reform plan.

(4) The Department shall collaborate with the organization to implement the child welfare reform plan. The Department shall submit a report to the Committee no later than September 15, 2019. The report shall describe progress made on implementation to date, implementation plans and time lines for the subsequent 24 months, and a summary of significant challenges encountered during implementation.

(5) The Department shall conduct a comprehensive review of every policy published by the Department related to child welfare. The Department shall revise existing policies and adopt new policies as necessary to align departmental guidance with the law as well as the systemic, policy, and practice changes resulting from both regionalization of the social services system and child welfare reform. The Department shall consult with agency attorneys and the School of Government at the University of North Carolina at Chapel Hill to confirm that each policy is authorized by statute or regulation. Prior to finalizing each policy, the Department shall provide the policy to the outside organization for review. The outside organization shall monitor the implementation of the policy review and revision process and submit bimonthly reports to the Committee beginning no later than September 15, 2019.

SECTION 2.2.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of three million one hundred thousand dollars ($3,100,000) in nonrecurring funds for the 2018-2019 fiscal year to implement the provisions of Section 2.1 of this act.

SECTION 2.2.(b) This section becomes effective July 1, 2017.

PART III. LOCAL DSS; CORRECTIVE ACTION

SECTION 3.1. G.S. 108A-74 reads as rewritten:

"**§ 108A-74. ~~County~~ Local department failure to ~~provide services; meet~~ required standards in child welfare; corrective action; State intervention in or control of service delivery.**

(a) Notwithstanding any other provision of law to the contrary, the Secretary ~~of Health and Human Services~~ may take action in accordance with this section to ensure the delivery of child welfare services in accordance with State laws and applicable rules. As used in this section, the ~~terms:~~following definitions shall apply:

(1) ~~"County department of social services" also means the~~ Department of social services. – The department responsible for administration of the social services and public assistance programs in a county. It includes a county department of social services, a consolidated human services agency, or a regional social services department, whichever ~~applies;~~applies.

(2) ~~"County director of social services" also means the~~ Director of social services. – The person responsible for managing and administering the department of social services, including a county social services director, a regional social services director, or a human services director, whichever ~~applies; and~~applies.

(3) ~~"County board of social services" also means the~~ Board of social services. – The governing body responsible for oversight of the department of social services, a regional board of social services, a consolidated human services board, or a board of county commissioners that has assumed the powers and duties of a social services governing board pursuant to G.S. 153A-77(a), whichever applies.

(4) Child welfare program. – Protective services related to juveniles alleged to be abused, neglected, or dependent as required by Chapter 7B of the General Statutes and includes the placement of children in substitute care.

(a1) The Secretary shall develop a standard set of performance and outcome metrics for child welfare services. Departments of social services shall satisfy mandated performance requirements that are based on those metrics.

(a2) If a department of social services fails to meet the performance requirements for three consecutive months or for five months within any consecutive 12-month period, the Secretary and the department of social services shall enter into a joint corrective action plan within 60 working days. The plan shall specifically identify each of the following components:

(1) The duration of the joint corrective action plan, not to exceed 12 months. If the Secretary determines that the department of social services has not shown measurable progress within six months, the Secretary may summarily conclude that the department of social services has failed to successfully complete a joint corrective plan and may proceed with steps necessary to temporarily assume administrative responsibilities of the department of social services. If the Secretary determines the department of social services has shown measurable progress within six months, the Secretary may extend the joint corrective action plan by six months, but in no case shall a joint corrective action plan exceed 18 months.

(2) The performance requirements for the department of social services that constitute successful completion of the joint corrective action plan.

(3) An acknowledgement that failure to successfully complete the joint corrective action plan shall result in temporary assumption of all or part of the department of social services' child welfare program administration.

(b) If the Secretary ~~of Health and Human Services~~ determines that a ~~county~~ department of social services ~~is not providing child protective services, foster care services, or adoption services in accordance with State law and with applicable rules adopted by the Social Services Commission, or fails to demonstrate reasonable efforts to do so,~~ has failed to successfully complete the joint corrective action plan, then the ~~Secretary, after providing written notification of intent to the county director of social services, to the chair of the county board of~~

~~commissioners, and to the chair of the county board of social services, and after providing them with an opportunity to be heard, may intervene in the particular service or services in question. Intervention includes, but is not limited to, the following activities:~~Secretary shall give the board of county commissioners, the department of social services, the county manager, and the board of social services at least 30 days' notice that the Secretary intends to temporarily assume all or part of the department's child welfare program administration in accordance with subsection (c) of this section. In a regional department of social services, notice shall be provided to boards of county commissioners and county managers for all counties served by the region.

~~(1) Sending staff of the Department of Health and Human Services to the county department of social services to provide technical assistance and to monitor the services being provided;~~

~~(2) Establishing a corrective plan of action to correct inappropriate policies and procedures; and~~

~~(3) Advising county personnel as to appropriate policies and procedures.~~

~~If within 60 days of completion of the intervention activities, the Secretary finds that the county department of social services is not providing in accordance with State laws and applicable rules the particular service or services for which intervention was initiated, or has not demonstrated reasonable efforts to do so, the Secretary shall withhold State and federal child welfare services administrative funds until the particular service or services are provided in accordance with State laws and applicable rules.~~

(c) ~~If the Secretary determines that a county department of social services is not providing child protective, foster care, or adoption services in accordance with State law and with applicable rules adopted by the Social Services Commission, or fails to demonstrate reasonable efforts to do so, and the failure to provide the services poses a substantial threat to the safety and welfare of children in the county who receive or are eligible to receive the services, then the Secretary, after providing written notification of intent to the chair of the county board of commissioners, to the chair of the county board of social services, and to the county director of social services, and after providing them with an opportunity to be heard, shall withhold funding for the particular service or services in question and shall ensure the provision of these services through contracts with public or private agencies or by direct operation by the Department of Health and Human Services.~~Notwithstanding any provision of law to the contrary, if a department of social services fails to successfully complete its joint corrective action plan, the Secretary shall, within 30 calendar days, temporarily assume all or part of the department's child welfare program administration upon giving notice as required by subsection (b) of this section. During the period the Secretary assumes administration of the child welfare program, the following shall occur:

(1) The Secretary shall administer the child welfare program in a county or region. Administration by the Secretary may include direct operation by the Department, including supervision of child welfare program staff, or contracts for operation, to the extent permitted by federal law.

(2) The department of social services shall be divested of administrative authority for any component of the child welfare program the Secretary assumes.

(3) The director of social services shall be divested of all service delivery powers conferred upon the director by G.S. 108A-14 and other applicable State law as it pertains to the services in question. The Secretary may assign any of the powers and duties of the director of social services to the Director of the Division of Social Services of the Department or a contractor, as the Secretary deems necessary and appropriate to continue the provision of services in the county. If the director delegates any authority to staff

pursuant to G.S. 108A-14(b), delegated authority shall remain in effect until the Secretary, or the Secretary's designee, specifically revokes the delegation.

(4) The Secretary shall direct and oversee the expenditure of all funding for the administration of the components of the child welfare program assumed by the Secretary.

(5) The department of social services shall not withdraw funds previously obligated or appropriated for child welfare program administration and services. The department of social services shall continue to pay the county or region's nonfederal share for the child welfare program services and administration.

(6) The Secretary shall work with the department of social services to develop a plan for the department to resume child welfare program administration.

(7) The Secretary shall inform the appropriate board or boards of county commissioners, the county manager or managers, the director of social services, and the board of social services of key activities and ongoing concerns during the temporary assumption of child welfare administration.

(c1) Upon the Secretary's determination that the department of social services is able to meet performance requirements for child welfare programs and that program administration responsibilities should be restored to the department of social services, the Secretary shall notify the board of county commissioners, the department of social services, the county manager, and the board of social services that the temporary assumption of child welfare program administration will be terminated and the effective date of the termination. Upon termination, the department of social services shall resume its full authority to administer the child welfare program.

~~(d) In the event that the Secretary assumes control of service delivery pursuant to subsection (c) of this section, the county director of social services shall be divested of all service delivery powers conferred upon the director by G.S. 108A-14 and other applicable State law as the powers pertain to the services in question. Upon assumption of control of service delivery, the Secretary may assign any of the powers and duties of the county director of social services to the Director of the Division of Social Services of the Department of Health and Human Services or to a contractor as the Secretary deems necessary and appropriate to continue the provision of the services in the county.~~

~~(e) In the event the Secretary takes action under this section, the Department of Health and Human Services shall, in conjunction with the county board of commissioners, the county board of social services, and the county director of social services develop and implement a corrective plan of action. The Department of Health and Human Services shall also keep the chair of the county board of commissioners, the chair of the county board of social services, and the county director of social services informed of any ongoing concerns or problems with the delivery of the services in question.~~

~~(f) Upon the Secretary taking action pursuant to subsection (c) of this section, county funding of the services in question shall continue and at no time during the period of time that the Secretary is taking action shall a county withdraw funds previously obligated or appropriated for the services. Upon the Secretary's assumption of the control of service delivery, the county shall also pay the nonfederal share of any additional cost that may be incurred to operate the services in question at the level necessary to comply fully with State law and Social Services Commission rules.~~

~~(g) During the period of time that the Secretary is taking action pursuant to subsection (c) of this section, the Department of Health and Human Services shall work with the county board of commissioners, the county board of social services, and the county director of social services, to enable service delivery to be returned to the county if and when the Secretary has~~

~~determined that services can be provided by the county in accordance with State law and applicable rules.~~"

SECTION 3.2. Section 3.1 of this act becomes effective six months after all 100 counties in the State have implemented the child welfare component to the North Carolina Families Accessing Services through Technology (NC FAST) system.

PART IV. CHILD WELL-BEING TRANSFORMATION COUNCIL

SECTION 4.1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"Article 81.

"Child Well-Being Transformation Council.

"**§ 143-775. Child Well-Being Transformation Council established; membership; qualifications; vacancies.**

(a) Purpose; Findings. – The welfare of North Carolina's children is a priority. There are many public and private agencies and organizations across the State that are involved with promoting the welfare of children and protecting them from harm, such as those involving child care, schools, health care providers, social services agencies, and juvenile justice programs. Though these agencies and organizations provide important services, they often fail to collaborate, coordinate, and communicate about those services. A more systematic and coordinated approach to services will help ensure that the State achieves the best possible outcomes for children. Therefore, the General Assembly finds that it is essential that a single body serve as a means for coordination, collaboration, and communication among agencies and organizations involved in providing public services to children.

(b) Creation and Membership. – There is established the North Carolina Child Well-Being Transformation Council (Council). The Council shall be located administratively in the General Assembly. The Council shall consist of 13 members serving staggered terms. In making appointments, each appointing authority shall select members who have appropriate experience and knowledge of the issues to be examined by the Council and shall strive to ensure members are appointed who represent the geographical, political, gender, and racial diversity of this State. The initial Council members shall be appointed on or after July 1, 2018, as follows:

(1) Three members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate. Of the members appointed under this subdivision, one shall be a member of the Senate who shall serve for a term of two years, one shall be a representative from the Administrative Office of the Courts who shall serve for a term of three years, and one shall be a representative from a child welfare private provider organization who shall serve a one-year term.

(2) Three members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives. Of the members appointed under this subdivision, one shall be a member of the House of Representatives who shall serve for a term of two years, one shall be a representative from the Department of Public Instruction who shall serve for a term of three years, and one shall be a representative from Indigent Defense Services who shall serve a one-year term.

(3) Seven members shall be appointed by the Governor. Of the members appointed under this subdivision, one shall be a representative from the Department of Health and Human Services, Division of Child Development and Early Education, who shall serve for a term of three years, one shall be a representative from the Department of Health and Human Services, Division of Social Services, who shall serve for a term of three years, one shall be a

representative from the Department of Public Safety, Division of Juvenile Justice, who shall serve for a term of two years, one shall be a representative from the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, who shall serve for a term of two years, one shall be a representative from the Guardian ad Litem program who shall serve a term of two years, one shall be a representative from Disability Rights NC who shall serve a one-year term, and one shall be a representative from the North Carolina Pediatric Society who shall serve a one-year term.

(c) Terms; Vacancies. – Upon the expiration of the terms of the initial Council members, each member shall be appointed for a term of four years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms. A vacancy shall be filled within 30 days by the authority making the initial appointment.

(d) Organization. – The Council shall elect from its membership a chair and vice-chair to each serve one-year terms. The Council shall meet on a quarterly basis each year upon the call of the chair. A quorum of the Council is seven members. No action may be taken except by a majority vote at a meeting at which a quorum is present. The Open Meetings Law pursuant to Article 33 of Chapter 143 of the General Statutes and the Public Records Act under Chapter 132 of the General Statutes shall apply to the Council.

(e) Funding. – From funds available to the General Assembly, the Legislative Services Commission shall allocate monies to fund the work of the Committee. Members of the Committee shall receive subsistence and travel expenses as provided in G.S. 120-3.1 and G.S. 138-5.

(f) Staff. – The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Council in its work. Upon the direction of the Legislative Services Commission, the Director of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Council. The expenses for clerical employees shall be borne by the Council.

"**§ 143-776. Powers and duties.**

(a) Upon its establishment, the Council shall direct its initial focus on the following initiatives:

(1) Mapping the network of child-serving agencies and organizations in the State.

(2) Cataloging examples of failures in coordination, collaboration, and communication in the context of child protective services.

(3) Reviewing the work of bodies similar to the Council operating in other states to identify promising practices and focus areas for the Council's work.

(b) Beginning July 1, 2020, the Council shall focus on promoting coordination, collaboration, and communication of child-serving agencies involved with the child protective services system. In addition, the Council shall do the following:

(1) Monitor the process of regionalization.

(2) Monitor the process of child welfare reform.

(3) Recommend changes in law, policy, or practice necessary to remedy gaps in coordination, collaboration, and communication between the new regional social services departments and other agencies and organizations involved with the same populations.

(c) By 2022, and thereafter, the Council shall expand the scope of its work to encompass evaluation of child-centered programs and services beyond the child protective services system. The Council shall take appropriate steps to identify gaps in coordination, collaboration, and communication and recommend changes in law, policy, or practice

necessary to remedy remaining gaps. The Council's authority extends to any publicly funded program that serves children.

(d) The Council shall submit a report to the 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, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by June 30 of each year. The report shall include a summary of the Council's work for the previous year, any findings and recommendations for change, and a work plan for the upcoming year.

(e) The Council is authorized to accept gifts or grants from other sources to support administration of the Council."

SECTION 4.2.(a) There is appropriated from the General Fund to the Legislative Services Commission the sum of twelve thousand six hundred ninety-two dollars ($12,692) in nonrecurring funds for the 2018-2019 fiscal year for purposes of assisting the Child Well-Being Transformation Council established pursuant to Section 4.1 of this act.

SECTION 4.2.(b) This section becomes effective July 1, 2017.

PART V. DRIVERS LICENSE PILOT PROJECT

SECTION 5.1.(a) The General Assembly recognizes that not having a drivers license is a barrier to education, employment, health care, and other community-based activities for older youth in substitute care working toward independence. One of the biggest barriers to accessing a drivers license for such youth is the ability to obtain insurance. Therefore, to assist in this effort, the Department of Health and Human Services, Division of Social Services, shall establish a two-year pilot program that shall reimburse, on a first-come, first-served basis, youth and caregivers' costs associated with drivers license education, drivers license fees, insurance costs, and any other costs associated with obtaining a drivers license. The Division shall take appropriate steps to ensure proper advertising of the pilot program.

SECTION 5.1.(b) The Division of Social Services shall report on the pilot project to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2018.

SECTION 5.2.(a) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of seventy-five thousand dollars ($75,000) for the 2017-2018 fiscal year and the sum of seventy-five thousand dollars ($75,000) for the 2018-2019 fiscal year to conduct the pilot project established pursuant to Section 5.1 of this act.

SECTION 5.2.(b) This section becomes effective July 1, 2017.

PART VI. PILOT WAIVER FOR IAFT FOSTER PARENTS

SECTION 6.(a) The General Assembly has determined that in an effort to maximize funding, local management entities/managed care organizations (LME/MCOs) are utilizing Intensive Alternative Family Treatment (IAFT), which is a means of cost-effective, specialized foster care treatment service that is being used for many youth who would have previously been treated in Medicaid congregate care, such as psychiatric residential treatment facilities. The General Assembly finds that these higher-need youth are often (i) suspended or expelled from school or day programs and (ii) require multiple appointments on a weekly basis to address needs, such as therapy, medication management, and school individual education plans (IEPs). Further, in accordance with rules, foster parents are required to maintain outside employment while providing foster care, but the constant demands of meeting the needs of these foster youth often lead to disruption in placement as the foster parent is unable to meet those needs while maintaining the parent's employment obligations.

SECTION 6.(b) To that end, the Department of Health and Human Services, Division of Social Services (Division), shall establish a pilot program that will allow the Division to waive the employment requirement for foster parents. The Division shall solicit

participation in the pilot program from interested LME/MCOs. The participating LME/MCOs shall conduct comparison measures between existing IAFT outcomes and those of pilots to determine any impact the waiver may have on outside employment. LME/MCOs shall measure progress of the pilot waivers based on the expectation of meeting the following outcomes:

(1) Improved placement stability with less than twenty percent (20%) of moves of youth occurring due to therapeutic foster parent request.

(2) Seventy-five percent (75%) of youth and families meeting their treatment goals within the projected time frame.

(3) No more than a ten percent (10%) increase in higher-level hospital bed days.

SECTION 6.(c) LME/MCOs participating in the IAFT pilot waiver program shall provide a report on the outcomes of the pilots, along with any recommendations, to the Division. The Division shall then submit a report on the pilot waiver program to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018.

PART VII. TERMINATION OF PARENTAL RIGHTS/TIME FRAME FOR APPEALS

SECTION 7. G.S. 7B-1001(a)(5)b. reads as rewritten:

"(a) In a juvenile matter under this Subchapter, appeal of a final order of the court in a juvenile matter shall be made directly to the Court of Appeals. Only the following juvenile matters may be appealed:

...

(5) An order entered under G.S. 7B-906.2(b) with rights to appeal properly preserved, as follows:

...

b. A party who is a parent shall have the right to appeal the order if no termination of parental rights petition or motion is filed within ~~180~~ 65 days of the order."

PART VIII. TIME FRAME FOR LICENSURE APPROVAL/FOSTER CARE

SECTION 8.1. G.S. 131D-10.3 is amended by adding a new subsection to read:

"**§ 131D-10.3. Licensure required.**

...

(d1) Notwithstanding any other provision of law, the Department shall grant or deny a license to provide foster care or therapeutic foster care within three months from the date of application.

...."

SECTION 8.2. The Department of Health and Human Services, Division of Social Services, shall further examine the existing time frames for processing foster care and therapeutic foster care applications and determine methods to further reduce the time frames for approving or denying applications for licensure.

PART IX. EFFECTIVE DATE

SECTION 9. Except as otherwise provided, this act is effective when it becomes law.

Child/Family Protection and Accountability Act

Restructuring Social Services for Standardization and Efficiency

- Establishes a Working Group to make recommendations for a regional social services system in North Carolina. The plan may not include more than 30 regions.
- Final regionalization plan to the Joint Legislative Oversight Committee on Health and Human Services by March 31, 2019.
- New regions will be operational no later than January 1, 2022.

Reforming State DSS

- Contract with a third-party organization to evaluate the State's child welfare system and implement a reform plan to improve outcomes
- The entity will identify key outcome indicators to populate a Child Welfare System Transparency and Wellness Dashboard. The Dashboard shall serve as a performance report card.
- Grants HHS the authority to require a corrective action plan or to take over the administrative function if region is not meeting the expected outcomes identified on the dashboard

Child Welfare Transformation Council

- Creates a single body comprised of public and private agencies and organizations involved with promoting the welfare of children and protecting them from harm, such as childcare, schools, health care providers, social services agencies, and juvenile justice programs.
- Council serves as a means for enhancing coordination, collaboration, and communication among agencies and organizations involved in providing public services to children.

Foster Care Driving Pilot

- Establish a two-year pilot program that shall reimburse, on a first come first served basis, costs associated with obtaining a driver license, including insurance costs for youth in foster care.
- $75,000 for the 2017-2018 and 2018-2019 fiscal year

Pilot to Help Stabilize Children in Therapeutic Foster Care

- LME/MCOs may establish a pilot program that will allow a waiver of the employment requirement for Intensive Alternative Family Treatment (IAFT) foster parents.
- The participating LME/MCOs shall conduct comparison measures between existing IAFT outcomes and those of pilots to determine any impact the waiver has on increasing stabilization of the children in placement.

Reducing the time to Permanency for Children in Foster Care

- Reduces the time from 180 days to 65 days for a parent to appeal termination of parental rights.

Shorten the Processing Time for Foster Care Licensure

- Requires NC DHHS to further examine their existing timeline for processing licensure applications and determine methods to further reduce the timeline.
- Requires all foster care license applications to be processed within 3 months.

NC Child/Family Protection and Accountability Act

Social Services Regionalization Workgroup

Starts Upon Completion of Long Session **2017**
Workgroup Submit Plan to DHHS **Dec 1, 2018**

- Design with no more than 30 regions;
- Centralized administration in one county but keep physical presence for delivery of service in every county
- Workgroup co-chaired by House and Senate member
- Reps from County Commissioners, Social Services, AOC, DHHS, DSS Attorneys
- Focus on improvement of service delivery, quality of care, efficiency, accuracy, promote uniformity/standardization

DHHS Submits Draft to Joint HHS LOC HHS by **Jan 15, 2019**

DHHS Submits Final Regionalization Plan to Joint HHS LOC by **March 31,2019**

New Social Services Regions operational by **Jan 1, 2022**

3rd Party System Reform
State DSS Oversight

RFP for 3rd party by **January, 2018**
Complete Reform Plan 180 days after start date

- Reform State DSS through overarching strategic direction, governance and leadership, data analysis, standardization of a statewide practice framework
- **Identify measurable benchmarks to determine region performance;**
- Establish continuous quality improvement system

State DSS Corrective Oversight

- Create child welfare dashboard made up of a set of performance and outcomes metrics based on NC FAST data
- Gives state authority to implement corrective action plan (at Region DSS cost) if Region fails to meet benchmarks 3 consecutive or 5 out of 12 months
- If measurable progress is not identified in 6 months or resolved within 18 months, state DSS may assume administrative responsibility of region

Child Well-Being Transformation Council

- ✓ Council members shall be appointed on or after **July 1, 2018**
- Identify gaps in coordination, collaboration and communication of child serving agencies involved with child protective services
- Recommend changes in law, policy or practice to remedy identified gaps

Beginning **July 1, 2020**, the Council shall monitor the process of regionalization with the goal of identifying gaps between the new regions and other agencies involved with the same population.

By **2022**, and thereafter the Council shall expand the scope of its work to encompass evaluation of child-centered programs and services beyond child protective services.

Additional Aspects of Bill

- Driving pilot project for foster care
- Pilot to waive out-of-home work requirement for high level therapeutic foster parents
- Shorten the parent right to appeal TPR from 180 to 65 days
- Streamline foster family licensure process

SENATE BILL 368:
Notice of Medicaid SPA Submissions.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 19, 2017
Introduced by:	Sens. Hise, Pate, Krawiec	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 368 would require the Department of Health and Human Services (DHHS) to notify the General Assembly every time DHHS submits a Medicaid State Plan amendment for federal approval and every time DHHS decides not to submit a proposed State Plan amendment that was posted to DHHS's website.

CURRENT LAW: G.S. 108A-54.1A(d) requires DHHS to post amendments to the Medicaid State Plan, including Medicaid waivers and waiver amendments, at least 10 days prior to submitting the amendment to the federal government for approval. The statute requires DHHS to notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division when an amendment is posted to DHHS's website. Current law does not require DHHS to provide notice to the General Assembly when a State Plan amendment has been submitted for federal approval.

BILL ANALYSIS: Section 1 of the bill would add requirements for DHHS to give notice to the Joint Legislative Oversight Committee and Medicaid and NC Health Choice and the Fiscal Research Division regarding the submission of State Plan amendments that are posted to DHHS's website in accordance with G.S. 108A-54.1A(d). The bill would require DHHS to give notice when a State Plan amendment is submitted for federal approval and to give notice when DHHS decides not to submit a proposed State Plan amendment that was posted.

EFFECTIVE DATE: The bill would be effective when it becomes law and applies to State Plan amendments posted on DHHS's website on or after that date.

Karen Cochrane-Brown
Director

S368-SMTR-6 E1 -V-2

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 368

Short Title:	Notice of Medicaid SPA Submissions.	(Public)
Sponsors:	Senators Hise, Pate, Krawiec (Primary Sponsors); and Rabin.	
Referred to:	Rules and Operations of the Senate	

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PROVIDE NOTIFICATION TO THE GENERAL ASSEMBLY UPON THE SUBMISSION OR NON-SUBMISSION OF A MEDICAID STATE PLAN AMENDMENT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) The Department of Health and Human Services 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, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

(b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(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 Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval.

(d1) Upon the submission of an amendment to the State Plan to the federal government, the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been submitted.

If the Department determines that an amendment posted on its Web site in accordance with subsection (d) of this section will not be submitted to the federal government, then the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division upon making that determination.

(e) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(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 Medicaid and NC Health Choice and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 2. This act is effective when it becomes law and applies to amendments to the State Plan posted on the Department of Health and Human Services Web site on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S D

SENATE BILL 316
PROPOSED COMMITTEE SUBSTITUTE S316-CSSH-15 [v.2]
04/18/2017 05:20:49 PM

Short Title: Suicide Prevention/Awareness School Personnel. (Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A TRAINING PROGRAM ON YOUTH SUICIDE AWARENESS AND PREVENTION AND A RISK REFERRAL PROTOCOL FOR SCHOOL PERSONNEL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 25A of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-375.10. Youth suicide awareness and prevention training and risk referral protocol for school personnel.**

(a) Superintendent of Public Instruction Training Program and Protocol. – The Superintendent of Public Instruction, in consultation with the Department of Health and Human Services, Division of Public Health, shall develop a youth suicide awareness and prevention training program and a model risk referral protocol for local school administrative units and charter schools to provide to school personnel who work directly with students in grades six through 12. The training program shall consist of at least two hours of evidence-informed instruction to increase awareness of suicide, identification of risk factors and signs, and information for student referral for suicide prevention resources and support. The model risk referral protocol shall provide guidelines to local school administrative units on identification of at-risk students, suicide prevention procedures, and referral sources. The training program and model risk referral protocol shall be periodically reviewed and updated as necessary.

(b) Training and Protocol Requirements. – Each local school administrative unit shall provide the training program and model risk referral protocol developed by the Superintendent of Public Instruction pursuant to subsection (a) of this section to school personnel who work directly with students in grades six through 12 at no cost to the school employee. School personnel who work directly with students in grades six through 12 shall receive youth suicide awareness and prevention training within 12 months of employment with a local board of education and every five years thereafter while employed with that local board of education. The training may be offered in various formats, including electronically, either via videoconference or through an individual program of study that consists of at least two hours of instruction.

(c) Reporting. – As part of the Healthy Active Children Policy survey report required by State Board of Education policy, SHLT-000, each local school administrative unit shall report to the Department of Public Instruction on its compliance during the previous school year with the mandatory training and risk referral protocols required by this section on or before September 15 of each year. The Department of Public Instruction shall compile the reports received pursuant to this section and submit an overview of State compliance during the

previous school year with the mandatory training and risk referral protocols to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee on or before December 1 of each year.

(d) No local board of education, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.

(e) For purposes of this section, the term "school personnel" includes teachers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, administrators, administrative assistants, school safety resource officers, school nurses, social workers, psychologists, counselors, and any other school employee who has direct contact with students in grades six through 12."

SECTION 2. G.S. 115C-218.75 is amended by adding a new subsection to read:

"(g) Youth Suicide Awareness and Prevention Training and Risk Referral Protocol. – Each charter school may provide a youth suicide awareness and prevention training program and risk referral protocol to school personnel who work directly with students in grades six through 12 once every five years in accordance with G.S. 115C-375.10. Each charter school that elects to provide the training and referral protocol under this subsection shall report to the Department of Public Instruction on its compliance during the previous school year with the training and risk referral protocols in G.S. 115C-375.10 on or before September 15 of each year. No charter school board of directors, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 3. This act is effective when it becomes law and applies beginning with the 2018-2019 school year.

SENATE BILL 383:
Behav. Health Crisis EMS Transports/Medicaid.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 17, 2017
Introduced by:	Sens. Krawiec, Pate, Hise	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to First Edition S383-CSTR-4		

OVERVIEW: ***The PCS to Senate Bill 383 would require the Department of Health and Human Services (DHHS) to design a plan for adding Medicaid coverage for ambulance transports to behavioral health clinics instead of hospital emergency departments and to report to the General Assembly about the plan, including the expected cost of adding coverage and whether the Department intends to add the coverage.***

CURRENT LAW / BACKGROUND: Medicaid Clinical Coverage Policy 15 sets forth the criteria for Medicaid coverage of ambulance transports. Currently Medicaid covers ambulance transports only to specified destinations and does not cover transports to behavioral health clinics.

Section 12H.32 of the 2014 Budget Act, S.L. 2014-100, required DHHS to study the practice of reimbursing for ambulance transports that divert individuals in mental health crisis from hospital emergency departments to alternative appropriate locations for care and to propose necessary Medicaid policy changes. In a March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," DHHS reported the results of this study and proposed an option to seek to add Medicaid coverage for ambulance transports to alternative locations by requesting federal approval of a Medicaid State Plan amendment.

At the time the March 2015 report was submitted, G.S. 108A-54.1A(b) limited DHHS's authority to submit State Plan amendments for federal approval unless directed to do so by the General Assembly. In September 2015, Medicaid Transformation legislation, S.L. 2015-245, as amended by S.L. 2016-121, repealed G.S. 108A-54.1A(b) and gave DHHS the authority under G.S. 108A-54(e) to administer and operate the Medicaid program, including establishing and adjusting all program components except for eligibility, within the budget for the Medicaid program set by the General Assembly. Pursuant to the authority granted under G.S. 108A-54(e), DHHS can add Medicaid coverage for services, such as ambulance transports, as long as adding the coverage will not cause the Medicaid program to exceed the budget set by the General Assembly.

BILL ANALYSIS: The PCS omits Section 4 of the bill, which stated the intent of the General Assembly to provide funding to add Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics instead of hospital emergency departments if DHHS could not implement the coverage under its authority to manage the Medicaid program within the budget set by the General Assembly. The PCS also reorganizes the information in the other sections for clarity and to be consistent with the omission of Section 4 of the bill.

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 1 of the PCS states the General Assembly's intent to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to behavioral health clinics and directs DHHS to design a plan to add Medicaid coverage for ambulance transports to behavioral health clinics. The plan must ensure that the Emergency Medical Services (EMS) Systems that receive reimbursement: (1) are utilizing EMS providers who have received appropriate education related to individuals in behavioral health crisis, and (2) have partnerships with facilities that can offer appropriate care. DHHS's plan must also require EMS Systems to report on patient experiences and outcomes in their EMS System Plan.

Section 2 of the PCS requires DHHS to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017, on the plan for adding this coverage. The report must include the proposed reimbursement methodology to be utilized, a fiscal analysis of the anticipated cost of adding the coverage, whether DHHS intends to add the coverage or will need additional appropriations, and a time frame for submission and approval of any State Plan amendments expected to be submitted.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S D

SENATE BILL 383
PROPOSED COMMITTEE SUBSTITUTE S383-CSTR-4 [v.2]
04/17/2017 12:33:32 PM

Short Title: Behav. Health Crisis EMS Transports/Medicaid. (Public)

Sponsors:

Referred to:

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH MEDICAID REIMBURSEMENT FOR AMBULANCE TRANSPORTS OF MEDICAID RECIPIENTS IN BEHAVIORAL HEALTH CRISIS TO BEHAVIORAL HEALTH CLINICS OR ALTERNATIVE APPROPRIATE CARE LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (Department) March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," the Department shall design a plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The plan shall ensure the following:

(1) Medicaid reimbursement is contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that the EMS System has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals.

(2) An EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes in accordance with rules adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 2. No later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall include the following:

(1) The proposed reimbursement methodology to be utilized.

(2) An analysis of the financial impact of adding the coverage, including any anticipated costs to the Medicaid program.

(3) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e), or whether additional appropriations are required.

(4) If the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e), a time line for submission of any State Plan amendments

or any waivers necessary for implementation and expected implementation date.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

SENATE BILL 383

Short Title:	Behav. Health Crisis EMS Transports/Medicaid.	(Public)
Sponsors:	Senators Krawiec, Pate, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH MEDICAID REIMBURSEMENT FOR AMBULANCE TRANSPORTS OF MEDICAID RECIPIENTS IN BEHAVIORAL HEALTH CRISIS TO BEHAVIORAL HEALTH CLINICS OR ALTERNATIVE APPROPRIATE CARE LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (DHHS) March 1, 2015, report entitled "Ambulance Transports to Crisis Centers," DHHS shall evaluate the financial impact, including any anticipated cost to the Medicaid program, of establishing Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. Any reimbursement shall be contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that it has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals. Additionally, an EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes. Rules regarding the EMS System Plan requirements shall be adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 2. No later than December 1, 2017, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the evaluation of the financial impact of establishing Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall also include a plan of implementation and a time line for submission of any State Plan amendments or any waivers necessary for implementation.

SECTION 3. The Department of Health and Human Services, Division of Medical Assistance, shall submit any State Plan amendments or any waivers necessary to establish Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations to the Centers for Medicare and Medicaid Services (CMS). Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations shall not be implemented until CMS approval of any submitted State Plan amendments or waivers has been received.

SECTION 4. If Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis cannot be implemented under the authority granted to the Department of Health and Human Services under G.S. 108A-54(e), then it is the intent of the General Assembly to appropriate any funds necessary to cover the costs of implementation upon the approval of any submitted State Plan amendments or waivers by the Centers for Medicare and Medicaid Services.

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

SENATE BILL 316:
Suicide Prevention/Awareness School Personnel.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Education/Higher Education. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 18, 2017
Introduced by:	Sens. Krawiec, D. Davis, Pate	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	PCS to First Edition S316-CSSH-15		

OVERVIEW: The Proposed Committee Substitute (PCS) for Senate Bill 316 would provide for a training program on youth suicide awareness and prevention and a risk referral protocol for school personnel.

[As introduced, this bill was identical to H285, as introduced by Reps. Murphy, Hardister, Dollar, Dobson, which is currently in House Education - K-12.]

BILL ANALYSIS:

The PCS for SB 316 would create new statutes regarding youth suicide awareness and prevention training and risk referral protocols in Chapter 115C (Elementary and Secondary Education), Article 25A (Special Medical Needs of Students) and Article 14A (Charter Schools).

Section 1 of the PCS would enact G.S. 115C-375.10 which establishes a Training Program and Protocol, Training and Protocol Requirements, and Reporting Requirements

Training Program and Protocol - The PCS requires the Superintendent of the Department of Public Instruction, in consultation with the Division of Public Health, Department of Health and Human Services, to develop the following for local school administrative units and charter schools to provide to school personnel working directly with students in grades six through 12:

1. A youth suicide awareness and prevention training program which must consist of at least two hours of evidence-informed instruction to increase awareness of suicide, identification of risk factors and signs, and information for student referral for suicide prevention resources and support.
2. A model risk referral protocol which must provide guidelines on identification of at-risk students, suicide prevention procedures, and referral sources.

Both the training and the model risk referral protocol must be periodically reviewed and updated.

Training and Protocol Requirements – Each local school administrative unit must provide items 1 and 2 above to school personnel who work directly with students in grades six through 12 at no cost to the school employee. School personnel are required to receive the youth suicide awareness and prevention training within 12 months of employment with a local board of education and every five years

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

thereafter. The training may be offered in various formats including electronically via videoconference or through an individual program of study that consists of at least two hours of instruction.

Reporting – On or before September 15 of each year, each local school administrative unit must report to the Department of Public Instruction on compliance with the mandatory training and risk referral protocols for the previous school year. The Department is required to compile the reports and submit an overview of State compliance to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee on or before December 1 of each year.

No local board of education, nor its members, employees, or designees, agents or volunteers are liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required unless the act or omission amounts to gross negligence, wonton conduct, or intentional wrongdoing.

"School personnel" is defined as teachers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, administrators, administrative assistants, school safety resource officers, school nurses, social workers, psychologists, counselors, and any other school employee who has direct contact with students in grade six through 12.

Section 2 of the bill amends the law on charter schools [G.S. 115C-218.75] by adding a new subsection. The new subsection allows, but does not require a charter school to provide a youth suicide awareness and prevention training program and risk referral protocol to school personnel who work directly with students in grades six through 12 in accordance with statute [G.S. 115C-375.10] added by Section 1. If a charter school elects to provide the training and referral protocol, they are required to report to the Department of Public Instruction on compliance.

EFFECTIVE DATE: Senate Bill 316 becomes effective when it becomes law and applies beginning with the 2018-2019 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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SENATE BILL 316
PROPOSED COMMITTEE SUBSTITUTE S316-CSSH-15 [v.2]
04/18/2017 05:20:49 PM

Short Title: Suicide Prevention/Awareness School Personnel. (Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A TRAINING PROGRAM ON YOUTH SUICIDE AWARENESS AND PREVENTION AND A RISK REFERRAL PROTOCOL FOR SCHOOL PERSONNEL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 25A of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-375.10. Youth suicide awareness and prevention training and risk referral protocol for school personnel.**

(a) Superintendent of Public Instruction Training Program and Protocol. – The Superintendent of Public Instruction, in consultation with the Department of Health and Human Services, Division of Public Health, shall develop a youth suicide awareness and prevention training program and a model risk referral protocol for local school administrative units and charter schools to provide to school personnel who work directly with students in grades six through 12. The training program shall consist of at least two hours of evidence-informed instruction to increase awareness of suicide, identification of risk factors and signs, and information for student referral for suicide prevention resources and support. The model risk referral protocol shall provide guidelines to local school administrative units on identification of at-risk students, suicide prevention procedures, and referral sources. The training program and model risk referral protocol shall be periodically reviewed and updated as necessary.

(b) Training and Protocol Requirements. – Each local school administrative unit shall provide the training program and model risk referral protocol developed by the Superintendent of Public Instruction pursuant to subsection (a) of this section to school personnel who work directly with students in grades six through 12 at no cost to the school employee. School personnel who work directly with students in grades six through 12 shall receive youth suicide awareness and prevention training within 12 months of employment with a local board of education and every five years thereafter while employed with that local board of education. The training may be offered in various formats, including electronically, either via videoconference or through an individual program of study that consists of at least two hours of instruction.

(c) Reporting. – As part of the Healthy Active Children Policy survey report required by State Board of Education policy, SHLT-000, each local school administrative unit shall report to the Department of Public Instruction on its compliance during the previous school year with the mandatory training and risk referral protocols required by this section on or before September 15 of each year. The Department of Public Instruction shall compile the reports received pursuant to this section and submit an overview of State compliance during the

previous school year with the mandatory training and risk referral protocols to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee on or before December 1 of each year.

(d) No local board of education, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.

(e) For purposes of this section, the term "school personnel" includes teachers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, administrators, administrative assistants, school safety resource officers, school nurses, social workers, psychologists, counselors, and any other school employee who has direct contact with students in grades six through 12."

SECTION 2. G.S. 115C-218.75 is amended by adding a new subsection to read:

"(g) Youth Suicide Awareness and Prevention Training and Risk Referral Protocol. – Each charter school may provide a youth suicide awareness and prevention training program and risk referral protocol to school personnel who work directly with students in grades six through 12 once every five years in accordance with G.S. 115C-375.10. Each charter school that elects to provide the training and referral protocol under this subsection shall report to the Department of Public Instruction on its compliance during the previous school year with the training and risk referral protocols in G.S. 115C-375.10 on or before September 15 of each year. No charter school board of directors, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 3. This act is effective when it becomes law and applies beginning with the 2018-2019 school year.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 316

Short Title:	Suicide Prevention/Awareness School Personnel.	(Public)
Sponsors:	Senators Krawiec, D. Davis, Pate (Primary Sponsors); Lee, Smith-Ingram, and Waddell.	
Referred to:	Rules and Operations of the Senate	

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR A TRAINING PROGRAM ON YOUTH SUICIDE AWARENESS AND PREVENTION AND RISK REFERRAL PROTOCOL FOR SCHOOL PERSONNEL.

The General Assembly of North Carolina enacts:

SECTION 1. Article 25A of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-375.10. Youth suicide awareness and prevention training and risk referral protocol for school personnel.**

(a) State Board Training Program and Protocol. – The State Board of Education, in consultation with the Department of Health and Human Services, Division of Public Health, shall develop a youth suicide awareness and prevention training program and a model risk referral protocol for local school administrative units and charter schools to provide to school personnel who work directly with students in grades K through 12, including teachers, teacher assistants, bus drivers, cafeteria workers, janitorial staff, media coordinators, athletic coaches, administrators, administrative assistants, school safety resource officers, school nurses, social workers, psychologists, and counselors. The training program shall consist of at least two hours of evidence-informed instruction to increase awareness of suicide, identification of risk factors and signs, and information for student referral for suicide prevention resources and support. The model risk referral protocol shall provide guidelines to local school administrative units on identification of at-risk students, suicide prevention procedures, and referral sources. The training program and model risk referral protocol shall be periodically reviewed and updated as necessary.

(b) Training and Protocol Requirements. – Each local school administrative unit shall provide the training program and model risk referral protocol developed by the State Board of Education under subsection (a) of this section, or a locally developed plan that meets the requirements of subsection (c) of this section, to school personnel who work directly with students in grades K through 12 at no cost to the employee. A school employee who works directly with students in grades K through 12 shall receive training within 12 months of employment with a local board of education and annually thereafter while employed with that local board of education. The training may be offered in various formats, including electronically, through videoconferencing, or through an individual program of study of designated materials consisting of at least two hours of instruction.

(c) Locally Developed Training and Risk Referral Protocols. – A local board of education may comply with the training and protocol requirements of this section by

developing a local plan that includes, at a minimum, (i) conveying information on State and national data on suicide deaths and attempts, suicide methods, and at-risk populations, (ii) myths and attitudes about suicide, (iii) warning signs and symptoms for suicide, (iv) identification of at-risk students and steps for referring students to support services, (v) protective factors for prevention of suicide, and (vi) safe messaging to children. In addition, a local plan shall include protocols for implementation and mandatory training that include at least the following:

(1) A plan to include specialized training for student support personnel, including administrators, school nurses, counselors, social workers, and psychologists.

(2) A safety plan for the school in the event of (i) identification of a student as being at-risk of suicide, including a student help plan and immediate assistance and (ii) a suicide death or suicide attempt by a student enrolled in the school, including a care plan for peers and school personnel.

(3) Designation of a school employee as the school suicide prevention responder.

(4) A plan for communication with a parent or legal guardian of a student identified as at-risk, including safe transfer of the student to the parent or legal guardian.

(5) A plan for post-intervention for a student who has been identified as at-risk or has attempted suicide, including reentry into the classroom.

(d) Reporting. – By September 15 of each year, as part of the Healthy Active Children Policy survey report required by State Board of Education policy, SHLT-000, each local school administrative unit shall report to the Department of Public Instruction on prior school year compliance with the mandatory training requirements and prevention activities required by this section.

(e) No local board of education, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 2. G.S. 115C-218.75 is amended by adding a new subsection to read:

"(g) Youth Suicide Awareness and Prevention Training and Risk Referral Protocol. – Each charter school shall provide a youth suicide awareness and prevention training program and risk referral protocol to school personnel who work directly with students in grades K through 12 on an annual basis in accordance with G.S. 115C-375.10. By September 15 of each year, the charter school shall report to the Department of Public Instruction on prior school year compliance with required training requirements and prevention activities. No charter school board of directors, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act or omission of an act relating to the provision of, participation in, or implementation of the components of the training program or protocol required by this section unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing."

SECTION 3. This act is effective when it becomes law and applies beginning with the 2018-2019 school year.

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 19, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Les Spell	NCDPI
Burt Jenkins	NCDPI
Joel Faircloth	NCAREMS
Fred Bone	Bone Assoc.
Carson Hine	NVA
Ryan Blackledge	CoreHealthD
Cory Hand	NCHA
Sara Wilson	Alliance BHC
Brian Perkins	Alliance BHC
Bob Hemelwe	FCA
Scott Lasitza	KGANC
Lori Kroll	NVant
Doug Mayhew	Pitt County
Jim Harrell	BMA
Mike Jones	ACP
Stephen Kunkle	KMA

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 19, 2017

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Amanda Donovan	KTS
Sue Ann Forrest	NCMS
	SA
Dodie Benfer	CCR
Brenda	NCSJC
Muffy Grant	Prevent child Abuse NC
Tim Bryson	Novants
Dana Simps	SA
Martha Babcock	PPAB
Leanne Winner	NCSBA
Susan Osborne	Alamance DSS
Bill Hussey	DPI
Mary Gardner	GSK
Mike McBrayer	Bayer
Chris McClure	BP

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VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 19, 2017

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Fred Waddle	Eastern Seals UCP
Betsy Lutten	American Heart Assn
CHRIS DILLON	WAKE
Judy McArn	DHHS
Verna Donnelly	DHHS
Susan R. Delaney	NCANP
Amy Hawkins	NCANP
Traci Hobson	NANP
Maureen Dunn	NCANP
Lee Dobson	BAYADA
Elizabeth Everette	DHHS - DCDEE
Heather Lafferty	DHHS - DCDEE
Skye David	NEWFRAME
Caitlin Little	UNC SOG
Caroline Miller	AMGA
Matt Anderson	CHS NC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 19, 2017

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Matt Gross	NC Child
Mike Leighs	NCPC
David Heinen	NC Center for Nonprofits
Jake Sipe	NCFPC
Preyanka Makadia	NCAFP
Nathan Copeland	NCPA
Chris Holler	CSH
Ben Popkin	DHHS
Kelly Vogel	DLPCC
Sarah Wolfe	NMC
Kevin Wilkinson	NC Superintendent
GERRY COHEN	NM
Lori Ann Morris	LHA

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 19, 2017

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Robb Jansen	NCSBE
Phoebe Landon	MWC
Sarah McQuillan	KGANC
Katy Kingsbury	3P
Debbie Parkman	Parkman Law
Sheree Wodicka	NC Alliance of YMCAs
Rachel Bealin	RPBlaw
Sharon Thrisch	Prevent Child Abuse NC
Susan Ulm	Duke Energy

09-21-201

Senate Committee on Health Care
Thursday, April 20, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 20, 2017, in Room 643 of the Legislative Office Building. Sixteen members were present.

Sen. Ralph Hise, Chair, presided.

He advised that any members of the public who would like to speak on a bill should check in with the sergeant-at-arms, and the committee would try to accommodate their speaking. Sergeants-at-Arms were Charles Marsalis, Becky Myrick, and Hal Roach.

Sen. Hise recognized Sen. Krawiec to present SB 383–Behav. Health Crisis EMS Transports/Medicaid., which was brought before the committee yesterday as a PCS. Sen. Krawiec offered to answer further questions about the bill. Sen. D. Davis moved for a favorable report of the PCS. The motion passed.

Sen. Britt was recognized to present SB 384–The Pharmacy Patient Fair Practices Act. Sen. Britt explained the bill and offered to answer questions. Sen. Newton offered an amendment, which Jason Moran-Bates of Legislative Analysis Division explained. The amendment passed. Sen. Hise recognized Abigail Stoddard of Prime Therapeutics, who spoke on the bill and took questions from committee members. Mike James, of the Association of Community Pharmacists, was recognized to speak and answered questions of committee members. Sen. Harrington moved for a favorable report of the amended bill rolled into a PCS. The motion passed.

Sen. Britt was again recognized to present SB 350–Amend Drug Laws/Ellison v. Treadway. Sen. Newton offered an amendment to correct a math error. The motion to amend the bill passed. Sen. Pate moved for a favorable report to the amended bill, rolled into a PCS. The motion passed.

Sen. Hise recognized Sen. Krawiec who presented SB 608–I/DD Services Waiting List Transparency. Sen. Robinson moved for a favorable to the bill. The motion passed.

Sen. Brock was recognized and presented SB 160–Handicap Parking Privilege Certification. Sen. Lowe and Sen. Horner moved for a favorable report of the bill. The motion passed.

The meeting adjourned at 10:50 AM.

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Principal Clerk _____
Reading Clerk _____

Corrected #3: SB 160 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
Thursday	April 20, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 383	Behav. Health Crisis EMS Transports/Medicaid.	Senator Krawiec Senator Pate Senator Hise
SB 384	The Pharmacy Patient Fair Practices Act.	Senator Britt Senator Rabon Senator Meredith
SB 350	Amend Drug Laws/Ellison v. Treadway.	Senator Britt Senator Tucker Senator J. Jackson
SB 608	I/DD Services Waiting List Transparency.	Senator Tucker Senator Krawiec Senator Horner
SB 160	Handicap Parking Privilege Certification.	Senator Brock Senator Meredith Senator Hise

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

Senate Committee on Health Care
Thursday, April 20, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Senator Hise, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 383	Behav. Health Crisis EMS Transports/Medicaid.	Senator Krawiec Senator Pate Senator Hise
SB 384	The Pharmacy Patient Fair Practices Act.	Senator Britt Senator Rabon Senator Meredith
SB 350	Amend Drug Laws/Ellison v. Treadway.	Senator Britt Senator Tucker Senator J. Jackson
SB 608	I/DD Services Waiting List Transparency.	Senator Tucker Senator Krawiec Senator Horner
SB 160	Handicap Parking Privilege Certification.	Senator Brock Senator Meredith Senator Hise

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 20, 2017

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

FAVORABLE

SB **160** Handicap Parking Privilege Certification.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

SB **608** I/DD Services Waiting List Transparency.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

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

SB **383** Behav. Health Crisis EMS Transports/Medicaid.

Draft Number:	S383-PCS45412-TR-4
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Senator Andrew C. Brock will handle SB 160
Senator Joyce Krawiec will handle SB 608
Senator Joyce Krawiec will handle SB 383

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 20, 2017

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

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

SB **384** The Pharmacy Patient Fair Practices Act.

Draft Number:	S384-PCS15188-BC-16
Sequential Referral:	Judiciary
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Danny Earl Britt, Jr. will handle SB 384

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, April 20, 2017

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

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

SB **350** **(CS#1)** Amend Drug Laws/Ellison v. Treadway.

Draft Number:	S350-PCS35294-TY-9
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Danny Earl Britt, Jr. will handle SB 350

SENATE BILL 383:
Behav. Health Crisis EMS Transports/Medicaid.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 17, 2017
Introduced by:	Sens. Krawiec, Pate, Hise	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to First Edition S383-CSTR-4		

OVERVIEW: The PCS to Senate Bill 383 would require the Department of Health and Human Services (DHHS) to design a plan for adding Medicaid coverage for ambulance transports to behavioral health clinics instead of hospital emergency departments and to report to the General Assembly about the plan, including the expected cost of adding coverage and whether the Department intends to add the coverage.

CURRENT LAW / BACKGROUND: Medicaid Clinical Coverage Policy 15 sets forth the criteria for Medicaid coverage of ambulance transports. Currently Medicaid covers ambulance transports only to specified destinations and does not cover transports to behavioral health clinics.

Section 12H.32 of the 2014 Budget Act, S.L. 2014-100, required DHHS to study the practice of reimbursing for ambulance transports that divert individuals in mental health crisis from hospital emergency departments to alternative appropriate locations for care and to propose necessary Medicaid policy changes. In a March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," DHHS reported the results of this study and proposed an option to seek to add Medicaid coverage for ambulance transports to alternative locations by requesting federal approval of a Medicaid State Plan amendment.

At the time the March 2015 report was submitted, G.S. 108A-54.1A(b) limited DHHS's authority to submit State Plan amendments for federal approval unless directed to do so by the General Assembly. In September 2015, Medicaid Transformation legislation, S.L. 2015-245, as amended by S.L. 2016-121, repealed G.S. 108A-54.1A(b) and gave DHHS the authority under G.S. 108A-54(e) to administer and operate the Medicaid program, including establishing and adjusting all program components except for eligibility, within the budget for the Medicaid program set by the General Assembly. Pursuant to the authority granted under G.S. 108A-54(e), DHHS can add Medicaid coverage for services, such as ambulance transports, as long as adding the coverage will not cause the Medicaid program to exceed the budget set by the General Assembly.

BILL ANALYSIS: The PCS omits Section 4 of the bill, which stated the intent of the General Assembly to provide funding to add Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics instead of hospital emergency departments if DHHS could not implement the coverage under its authority to manage the Medicaid program within the budget set by the General Assembly. The PCS also reorganizes the information in the other sections for clarity and to be consistent with the omission of Section 4 of the bill.

Karen Cochrane-Brown
Director

S383-SMTR-7 CSTR-4 -V-3

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 1 of the PCS states the General Assembly's intent to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to behavioral health clinics and directs DHHS to design a plan to add Medicaid coverage for ambulance transports to behavioral health clinics. The plan must ensure that the Emergency Medical Services (EMS) Systems that receive reimbursement: (1) are utilizing EMS providers who have received appropriate education related to individuals in behavioral health crisis, and (2) have partnerships with facilities that can offer appropriate care. DHHS's plan must also require EMS Systems to report on patient experiences and outcomes in their EMS System Plan.

Section 2 of the PCS requires DHHS to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017, on the plan for adding this coverage. The report must include the proposed reimbursement methodology to be utilized, a fiscal analysis of the anticipated cost of adding the coverage, whether DHHS intends to add the coverage or will need additional appropriations, and a time frame for submission and approval of any State Plan amendments expected to be submitted.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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SENATE BILL 383
PROPOSED COMMITTEE SUBSTITUTE S383-CSTR-4 [v.2]
04/17/2017 12:33:32 PM

Short Title: Behav. Health Crisis EMS Transports/Medicaid. (Public)

Sponsors:

Referred to:

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH MEDICAID REIMBURSEMENT FOR AMBULANCE TRANSPORTS OF MEDICAID RECIPIENTS IN BEHAVIORAL HEALTH CRISIS TO BEHAVIORAL HEALTH CLINICS OR ALTERNATIVE APPROPRIATE CARE LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (Department) March 1, 2015, legislative report entitled "Ambulance Transports to Crisis Centers," the Department shall design a plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The plan shall ensure the following:

(1) Medicaid reimbursement is contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that the EMS System has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals.

(2) An EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes in accordance with rules adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 2. No later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall include the following:

(1) The proposed reimbursement methodology to be utilized.

(2) An analysis of the financial impact of adding the coverage, including any anticipated costs to the Medicaid program.

(3) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e), or whether additional appropriations are required.

(4) If the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e), a time line for submission of any State Plan amendments

or any waivers necessary for implementation and expected implementation date.

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

SENATE BILL 383

Short Title:	Behav. Health Crisis EMS Transports/Medicaid.	(Public)
Sponsors:	Senators Krawiec, Pate, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH MEDICAID REIMBURSEMENT FOR AMBULANCE TRANSPORTS OF MEDICAID RECIPIENTS IN BEHAVIORAL HEALTH CRISIS TO BEHAVIORAL HEALTH CLINICS OR ALTERNATIVE APPROPRIATE CARE LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. It is the intent of the General Assembly to provide opportunities to divert individuals in behavioral health crisis from hospital emergency departments to alternative appropriate care locations. Consistent with Option 1 outlined in the Department of Health and Human Services' (DHHS) March 1, 2015, report entitled "Ambulance Transports to Crisis Centers," DHHS shall evaluate the financial impact, including any anticipated cost to the Medicaid program, of establishing Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. Any reimbursement shall be contingent upon an Emergency Medical Services (EMS) System's ability to demonstrate its EMS providers have received appropriate education in caring for individuals in behavioral health crisis and that it has at least one partnership with a receiving facility that is able to provide care appropriate for those individuals. Additionally, an EMS System shall be required to include in its EMS System Plan a report on patient experiences and outcomes. Rules regarding the EMS System Plan requirements shall be adopted by the Department of Health and Human Services, Division of Health Regulation, Office of Emergency Medical Services.

SECTION 2. No later than December 1, 2017, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the evaluation of the financial impact of establishing Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations. The report shall also include a plan of implementation and a time line for submission of any State Plan amendments or any waivers necessary for implementation.

SECTION 3. The Department of Health and Human Services, Division of Medical Assistance, shall submit any State Plan amendments or any waivers necessary to establish Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations to the Centers for Medicare and Medicaid Services (CMS). Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics or other alternative appropriate care locations shall not be implemented until CMS approval of any submitted State Plan amendments or waivers has been received.

SECTION 4. If Medicaid reimbursement for ambulance transports of Medicaid recipients in behavioral health crisis cannot be implemented under the authority granted to the Department of Health and Human Services under G.S. 108A-54(e), then it is the intent of the General Assembly to appropriate any funds necessary to cover the costs of implementation upon the approval of any submitted State Plan amendments or waivers by the Centers for Medicare and Medicaid Services.

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

SENATE BILL 384:
The Pharmacy Patient Fair Practices Act.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 19, 2017
Introduced by:	Sens. Britt, Rabon, Meredith	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 384 would require pharmacy benefits managers to comply with the pharmacy of choice requirements in G.S. 58-51-37. It would also require pharmacy benefits managers to permit pharmacists to discuss lower-cost alternative drugs with consumers and provide store direct delivery services. Pharmacy benefits managers would be prohibited from charging insureds a co-pay that exceeds the total submitted charges by a network pharmacy, charging pharmacies a fee for costs related to claim adjudication, recouping funds from pharmacies without complying with Article 4C of Chapter 90 of the General Statutes. Failure to comply with any of these requirements would be an unfair and deceptive trade practice.***

[As introduced, this bill was identical to H466, as introduced by Rep. Brenden Jones, which is currently in House Insurance.]

CURRENT LAW: Pharmacy benefits managers are entities who contract with pharmacies on behalf of insurers to administer prescription drug benefits. Currently, they are regulated in their placement of drugs on the maximum allowable cost price list by Article 56A of Chapter 58, but they are not subject to additional regulation.

BILL ANALYSIS: Senate Bill 384 would amend Article 56A of Chapter 58 by adding additional requirements for pharmacy benefits managers.

Section 1 would add definitions for "insured" and "pharmacist" to G.S.58-56A-1.

Section 2 would require pharmacy benefits managers to comply with the pharmacy choice provisions in G.S. 58-51-37. Section 2 would also require pharmacy benefits mangers to permit pharmacists to discuss an insured's cost share for a drug, disseminate information about lower-priced alternative drugs, sell a lower-priced alternative drug without penalty, and provide store direct delivery services. Pharmacy benefits managers would be prohibited from charging insureds co-payments that exceed the total charges submitted by a network pharmacy, charging fees or otherwise holding pharmacies responsible for the costs of adjudicating a claim, and recouping funds from pharmacies without complying with the requirements of Article 4C of Chapter 90, unless otherwise permitted by law. Failure to comply with the requirements of Section 2 would be an actionable unfair and deceptive trade practice under Chapter 75 of the General Statutes.

Section 3 would permit the Commissioner of Insurance to adopt rules to implement the act.

EFFECTIVE DATE: The bill would become effective October 1, 2017 and apply to all contracts entered into, renewed, or amended on or after that date.

Karen Cochrane-Brown
Director

S384-SMBC-33 E1 -V-2

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

SENATE BILL 384*

Short Title:	The Pharmacy Patient Fair Practices Act.	(Public)
Sponsors:	Senators Britt, Rabon, and Meredith (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2017

A BILL TO BE ENTITLED

AN ACT RELATING TO THE REGULATION OF PHARMACY BENEFIT MANAGERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-56A-1 reads as rewritten:

"**§ 58-56A-1. Definitions.**

The following definitions apply in this Article:

(1) Health benefit plan. – As defined in G.S. 58-50-110(11). This definition specifically excludes the State Health Plan for Teachers and State Employees.

(2) Insured. – An individual covered by a health benefit plan.

~~(2)~~(3) Insurer. – Any entity that provides or offers a health benefit plan.

~~(3)~~(4) Maximum allowable cost price. – The maximum per unit reimbursement for multiple source prescription drugs, medical products, or devices.

(5) Pharmacist. – A person licensed to practice pharmacy under Article 4A of Chapter 90 of the General Statutes.

~~(4)~~(6) Pharmacy. – A pharmacy registered with the North Carolina Board of Pharmacy.

~~(5)~~(7) Pharmacy benefits manager. – An entity who contracts with a pharmacy on behalf of an insurer or third-party administrator to administer or manage prescription drug benefits.

~~(6)~~(8) Third-party administrator. – As defined in G.S. 58-56-2."

SECTION 2. Article 56A of Chapter 58 of the General Statutes is amended by adding three new sections to read:

"**§ 58-56A-2. Pharmacy of choice.**

A pharmacy benefits manager shall comply with the pharmacy of choice requirements under G.S. 58-51-37.

"**§ 58-56A-3. Consumer protections.**

(a) A pharmacy benefits manager shall not prohibit a pharmacist or pharmacy from providing an insured information regarding the amount of the insured's cost share for a prescription drug and the clinical efficacy of a lower-priced alternative drug, if one is available. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefits manager for discussing any information described in this section or for selling a lower-priced drug to the insured if one is available.

(b) A pharmacy benefits manager shall not prohibit a pharmacist or pharmacy from offering and providing store direct delivery services to an insured as an ancillary service of the pharmacy.

(c) A pharmacy benefits manager shall not charge, or attempt to collect from, an insured a co-payment that exceeds the total submitted charges by the network pharmacy for which the pharmacy is paid.

(d) A pharmacy benefits manager's failure to comply with this section shall be considered an unfair and deceptive trade practice and shall be actionable under Chapter 75 of the General Statutes. Nothing in this subsection shall foreclose other remedies available under law or equity.

"**§ 58-56A-4. Pharmacy and pharmacist protections.**

(a) A pharmacy benefits manager may not charge a fee, or otherwise hold a pharmacist or pharmacy responsible, for costs relating to the adjudication of a claim.

(b) A pharmacy benefits manager may not recoup funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with the requirements under Article 4C of this Chapter, unless the recoupment is otherwise permitted or required by law. No pharmacist or pharmacy shall be penalized or retaliated against for exercising any rights under this Chapter.

(c) This section shall not apply to any licensed group health maintenance organization with an exclusive medical group contract that operates its own pharmacies.

(d) A pharmacy benefits manager's failure to comply with this section shall be considered an unfair and deceptive trade practice and shall be actionable under Chapter 75 of the General Statutes. Nothing in this subsection shall foreclose other remedies available under law or equity."

SECTION 3. The Commissioner of Insurance may adopt rules to implement this act.

SECTION 4. This act becomes effective October 1, 2017, and applies to all contracts entered into, renewed, or amended on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 384*

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

S384-ASH-12 [v.1]

Amends Title [NO]
First Edition

Date 4/20/17 ,2017

Senator Newton

moves to amend the bill on page 1, lines 22-26, by rewriting the lines to read:

"**SECTION 2.** Article 56A of Chapter 58 of the General Statutes is amended by adding two new sections to read:";

and on page 1, lines 27 through page 2, line 7, by rewriting the lines to read:

"**§ 58-56A-3. Consumer protections.**

(a) A pharmacy or pharmacist shall have the right to provide an insured information regarding the amount of the insured's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefits manager for discussing any information described in this section or for selling a lower-priced drug to the insured if one is available.

(b) A pharmacy benefits manager shall not, through contract, prohibit a pharmacy from offering and providing direct and limited delivery services to an insured as an ancillary service of the pharmacy, as delineated in the contract between the pharmacy benefits manager and the pharmacy.

(c) A pharmacy benefits manager shall not charge, or attempt to collect from, an insured a co-payment that exceeds the total submitted charges by the network pharmacy.";

And on page 2, lines 8-21, by rewriting the lines to read:

"**§ 58-56A-4. Pharmacy and pharmacist protections.**

(a) A pharmacy benefits manager may only charge a fee, or otherwise hold a pharmacy responsible for a fee relating to the adjudication of a claim if the fee is reported on the remittance advice of the adjudicated claim or is set out in contract between the pharmacy benefits manager and the pharmacy. This section shall not apply with respect to claims under

an employee benefit plan under the Employee Retirement Income Security Act of 1974 or Medicare Part D.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 350:
Amend Drug Laws/Ellison v. Treadway.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 20, 2017
Introduced by:	Sens. Britt, Tucker, J. Jackson	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	Second Edition		

OVERVIEW: Senate Bill 350 would specify that pharmaceutical pills do not fall under the felony "trafficking in opium" sentencing regime and create a new felony "trafficking in pharmaceuticals" offense and sentencing regime.

CURRENT LAW and BACKGROUND: Subsection (h) of G.S. 90-95 sets forth the violations and penalties for trafficking offenses in the Controlled Substances Act. "Trafficking in opium or heroin" is found in G.S. 90-95(h)(4) which provides the following mandatory sentencing structure based upon the amount of opium, opiate, salt, compound, derivative, or preparation of opium, including heroin, or mixture containing such substances involved:

4g – 14g	Class F	70 – 93 months	At least $50,000 fine
14g – 28g	Class E	90 – 120 months	At least $100,000 fine
28g or more	Class C	225 – 282 months	At least $500,000 fine

In 2013, the companion cases of State v. Ellison and State v. Treadway presented the question of whether prescription pharmaceutical tablets and pills could serve as opium for purposes of "trafficking in opium or heroin" pursuant to G.S. 90-95(h)(4). The Supreme Court held that, because G.S. 90-95(h)(4) explicitly provides that a defendant's criminal liability is based upon the total weight of the mixture involved, and because tablets and pills are mixtures, pharmaceutical tablets and pills that contain controlled substances prohibited under the statute may be considered opium for purposes of the trafficking statute. In its holding, the Court noted the "harsh results imposed by the statute" but determined that "[h]ad the General Assembly intended for prescription tablets and pills to fall outside the scope of the statute, it could have easily included plain language to that effect."

BILL ANALYSIS: Senate Bill 350 would specify that pharmaceutical pills, tablets, or capsules of an FDA approved substance containing an opiate do not qualify as "trafficking in opium." Instead, the bill clarifies that an offense involving less than 100 pills, tablets or capsules is to be punished pursuant to existing laws pertaining to Schedule I through VI controlled substances. For offenses involving 100 pills or more, the bill would create the following new mandatory sentencing regime for "trafficking in pharmaceuticals" based upon the number of pills involved:

100 pills – 400 pills	Class G	35 – 51 months	At least $25,000 fine
400 pills – 600 pills	Class F	70 – 90 months	At least $50,000 fine
600 pills or more	Class D	175 – 222 months	At least $200,000 fine

Karen Cochrane-Brown
Director

S350-SMTY-32 E2 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

EFFECTIVE DATE: This act would become effective December 1, 2017 and apply to offenses committed on or after that date.

SENATE BILL 350
Judiciary Committee Substitute Adopted 4/13/17

Short Title: Amend Drug Laws/Ellison v. Treadway. (Public)

Sponsors:

Referred to:

March 23, 2017

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT POSSESSION OF CERTAIN PRESCRIPTION DRUGS IS NOT PUNISHABLE AS TRAFFICKING IN OPIUM OR HEROIN AND TO SET OUT THE CRIMINAL PENALTY FOR THAT OFFENSE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-95(h)(4) reads as rewritten:

"(4) ~~Any~~ Except as provided in subdivision (4c) of this subsection, any person who sells, manufactures, delivers, transports, or possesses four grams or more of opium or opiate, or any salt, compound, derivative, or preparation of opium or opiate (except apomorphine, nalbuphine, analoxone and naltrexone and their respective salts), including heroin, or any mixture containing such substance, shall be guilty of a felony which felony shall be known as "trafficking in opium or heroin" and if the quantity of such controlled substance or mixture involved:

a. Is four grams or more, but less than 14 grams, such person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 93 months in the State's prison and shall be fined not less than fifty thousand dollars ($50,000);

b. Is 14 grams or more, but less than 28 grams, such person shall be punished as a Class E felon and shall be sentenced to a minimum term of 90 months and a maximum term of 120 months in the State's prison and shall be fined not less than one hundred thousand dollars ($100,000);

c. Is 28 grams or more, such person shall be punished as a Class C felon and shall be sentenced to a minimum term of 225 months and a maximum term of 282 months in the State's prison and shall be fined not less than five hundred thousand dollars ($500,000)."

SECTION 2. G.S. 90-95(h) is amended by adding a new subdivision to read:

"(4c) The illegal sale, delivery, transportation, or possession of pills, tablets, or capsules of a controlled substance that contains an opiate, as defined in G.S. 90-87(18), combined with a noncontrolled substance and that is a commercial drug product with FDA approval manufactured and distributed by a pharmaceutical company lawfully doing business in the United States shall be governed by this section and by subsections (b) and (d) of this section and shall not be governed by subdivision (4) of this subsection. Any

person who sells, delivers, or possesses less than 100 pills, tablets, or capsules of a controlled substance described in this subdivision shall not be guilty of trafficking in pharmaceuticals but may be punished pursuant to the provisions of subsections (b) and (d) of this section. Any person who sells, delivers, transports, or possesses 100 or more pills, tablets, or capsules of a controlled substance described in this subdivision shall be guilty of a felony which shall be known as "trafficking in pharmaceuticals," and if the quantity of such substance involved:

a. Is 100 or more pills, tablets, or capsules, but less than 400 pills, tablets, or capsules, the person shall be punished as a Class G felon and shall be sentenced to a minimum term of 35 months and a maximum term of 51 months in the State's prison and shall be fined not less than twenty-five thousand dollars ($25,000);

b. Is 400 or more pills, tablets, or capsules, but less than 600 pills, tablets, or capsules, the person shall be punished as a Class F felon and shall be sentenced to a minimum term of 70 months and a maximum term of 90 months in the State's prison and shall be fined not less than fifty thousand dollars ($50,000); or

c. Is 600 or more pills, tablets, or capsules, the person shall be punished as a Class D felon and shall be sentenced to a minimum term of 175 months and a maximum term of 222 months in the State's prison and shall be fined not less than two hundred thousand dollars ($200,000)."

SECTION 3. This act becomes effective December 1, 2017, and applies to offenses committed on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 350

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

S350-ATY-20 [v.2]

Amends Title [NO]
Second Edition

Date 4/20/17 ,2017

Senator Newton

moves to amend the bill on page 2, line 17 by deleting "90" and substituting "93".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 608:
I/DD Services Waiting List Transparency.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 20, 2017
Introduced by:	Sens. Tucker, Krawiec, Horner	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 608 would require local management entities/managed care organizations (LME/MCOs) to report certain information pertaining individuals on the waiting lists for the NC Innovations Medicaid waiver and for State-funded services for individuals with intellectual and developmental disabilities to the Department of Health and Human Services (DHHS) twice a year. The bill would also require DHHS to annually report to the General Assembly consolidated information from the LME/MCO reports to assist with funding priorities.

CURRENT LAW / BACKGROUND: LME/MCOs are regional, local governmental entities responsible for managing the delivery of publicly-funded services to individuals with intellectual and developmental disabilities through contracts with DHHS. LME/MCOs manage Medicaid services that are available to these individuals through the NC Innovations waiver as well as services for these individuals that are funded with only State funds. G.S. 122C-115.4(b)(8) requires LME/MCOs to maintain a waiting list of individuals with intellectual and developmental disabilities who are in need of these Medicaid and State-funded services but who are not receiving them. The waiting list for the NC Innovations waiver is also referred to as the Registry of Unmet Needs. G.S. 122C-115.4(b)(8) also requires LME/MCOs to report waiting list data annually to DHHS.

BILL ANALYSIS: The bill would require each LME/MCO to report every six months, beginning October 1, 2017, to DHHS on the number of individuals on the waiting lists for the NC Innovations Medicaid waiver and for State-funded services for individuals with intellectual and development disabilities. For each individual on the waiting lists, the LME/MCO would be required to provide information about the individual that includes: (1) age, (2) ethnicity, (3) living arrangement, (4) length of time on the waiting list, (5) services needed, (6) co-occuring mental health or substance abuse needs, (7) primary and secondary disabilities, and (8) county of residence.

The bill would require DHHS to consolidate the information received from all of the LME/MCOs, to remove all personally-identifying information, and to report the consolidated information to the General Assembly on January 1 of each year, in order to assist with funding priorities of the General Assembly.

The reporting requirements established in the bill would end once behavioral health services for Medicaid recipients are no longer excluded from the capitated Medicaid contracts that are required by Medicaid reform legislation, S.L. 2015-245.

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

Karen Cochrane-Brown
Director

S608-SMTR-8 E1 -V-3

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 608*

Short Title:	I/DD Services Waiting List Transparency.	(Public)
Sponsors:	Senators Tucker, Krawiec, and Horner (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

April 5, 2017

A BILL TO BE ENTITLED

AN ACT TO PROVIDE GREATER TRANSPARENCY REGARDING THE REGISTRY OF UNMET NEEDS FOR THE NORTH CAROLINA INNOVATIONS WAIVER AND THE WAITING LIST FOR STATE-FUNDED INTELLECTUAL AND DEVELOPMENTAL DISABILITY SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Beginning October 1, 2017, twice yearly, each Local Management Entities/Managed Care Organization (LME/MCO) shall provide to the Department of Health and Human Services (DHHS) the number of individuals within the LME/MCO's catchment area who are on the Registry of Unmet Needs for the North Carolina Innovations Waiver and who are on the waiting list for State-funded intellectual and developmental disability (I/DD) services. The following detailed information shall be provided for the individuals on either or both of these waiting lists:

(1) Age of each individual.
(2) Ethnicity of each individual.
(3) Current living arrangement of the individual.
(4) Length of time the individual has been on at least one of the two waiting lists.
(5) The documented services and supports needed by the individual when the individual first requested services, as well as the documented services and supports currently needed by the individual.
(6) Any documented co-occurring mental health or substance abuse needs the individual may have.
(7) The documented primary disability of the individual and any documented secondary disabilities that the individual may have.
(8) The county where the individual lives and, if applicable, the county of residence for Medicaid eligibility.

Each LME/MCO shall provide the information to the DHHS no later than April 1 and October 1 of each year. No later than January 1 of each year, in order to assist with funding priorities, the DHHS shall submit a report that consolidates all information received during the previous calendar year from the LME/MCOs regarding individuals who are waiting for I/DD services, and that removes any personally identifiable information, to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division.

Reports from LME/MCOs and from DHHS shall be required under this section until behavioral health services for Medicaid recipients are no longer excluded from capitated Prepaid Health Plan contracts, as defined by S.L. 2015-245, as amended.

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

SENATE BILL 160:
Handicap Parking Privilege Certification.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 19, 2017
Introduced by:	Sens. Brock, Meredith, Hise	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 160 authorizes licensed physician assistants and licensed nurse practitioners to certify applications to DMV for handicapped parking placards or license plates.***

CURRENT LAW: Under current law, G.S. 20-37.6(c1), the application to DMV for a handicapped license plate or placard must be certified by one of the following:

- licensed physician
- licensed ophthalmologist
- a licensed optometrist
- Division of Services for the Blind
- United States Department of Veterans Affairs

G.S. 90-18.3 currently states that "*Whenever a statute or State agency rule requires that a physical examination shall be conducted by a* ***physician****, the examination may be conducted and the form signed by a* ***nurse practitioner*** *or a* ***physician's assistant****, and a physician need not be present.*" DMV's position is that this statute doesn't apply to current G.S. 20-37.6(c1), because G.S. 90-18.3 applies to "examination", and G.S. 20-37.6 refers to "certification".

BILL ANALYSIS: Senate Bill 160 amends the current law on handicapped plates and placards, which requires medical certification, to make clear the certification can be done by **licensed physician assistants** or **licensed nurse practitioners**.

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

BACKGROUND:

- A **physician assistant** is a person licensed to perform medical functions as an assistant to a physician, including those duties authorized in G.S. 90-18.1.
- A **nurse practitioner** is a registered nurse who has: completed a post-graduate certificate nurse practitioner education program or obtains a Master's, or higher degree, in nursing or related field with primary focus on nursing; a certification by a national credentialing body; and is registered pursuant to Chapter 90.
- A bill on the same topic, House Bill 11, is currently in Senate Rules.

**Giles Perry, Staff to Senate Transportation substantially contributed to this summary.*

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 160

Short Title:	Handicap Parking Privilege Certification.	(Public)
Sponsors:	Senators Brock, Meredith, Hise (Primary Sponsors); and Britt.	
Referred to:	Rules and Operations of the Senate	

March 2, 2017

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT MEDICAL CERTIFICATION AND RECERTIFICATION REQUIREMENTS FOR HANDICAPPED PARKING PRIVILEGES MAY BE SATISFIED BY CERTIFICATION OF A LICENSED PHYSICIAN ASSISTANT OR A LICENSED NURSE PRACTITIONER THAT THE PERSON IS HANDICAPPED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-37.6(c1) reads as rewritten:

"(c1) Application and Renewal; Physician's Certification. – The initial application for a distinguishing license plate, removable windshield placard, or temporary removable windshield placard shall be accompanied by a certification of a licensed physician, a licensed ophthalmologist, a licensed optometrist, a licensed physician assistant, a licensed nurse practitioner, or the Division of Services for the Blind that the applicant is handicapped or by a disability determination by the United States Department of Veterans Affairs that the applicant is handicapped. The application for a temporary removable windshield placard shall contain additional certification to include the period of time the certifying authority determines the applicant will have the disability. Distinguishing license plates shall be renewed annually, but subsequent applications shall not require a medical certification that the applicant is handicapped. Removable windshield placards shall be renewed every five years, and, except for a person certified as totally and permanently disabled at the time of the initial application or a prior renewal under this subsection, the renewal shall require a medical recertification that the person is handicapped. Temporary removable windshield placards shall expire no later than six months after issuance."

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

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 20, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	Bennett
Brent Johnson	NASW-NC
Marian Cowell	NASW-NC
Reba Calvert	NCDMV
[illegible]	CSS
John Sne	NCFPC
Jacqueline Gonzalez	SCJ Staff
Sarah Wolfe	UNC
[illegible]	UNC
Sarah Ball	Burbacher & Assoc.
[illegible]	[illegible]
JOE LANIER	DSS
Darryl Childers	Governor's Office
GERRY COHEN	NM
Peter Netten	American Heart Assn
Ben Popkin	DHHS

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 20, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Abigail Stoddard	Prime Therapeutics
Ben Twilley	Express Scripts
Thomas Haldway	PhRMA
Karen Slocum	PAA-Anesthesiologist
Courtney Hennig	CVS Health
Jesse Goodson	DHHS/DHSR
Regina G. Crawford	EMS Mangment + Consultants
Fred Bone	Bone + Asso.
Joel Faircloth	NCAR & EMS
Meghan O'Donnell	Express Scripts
Abigail Stoddard	Prime
Marty Bocock	Prime
Colleen Kochanek	The Arc
John Nash	The Arc

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 20, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	DCG
Josh Maynard	GPM : Assoc
Peyton Maynard	[illegible]
[illegible]	NCMS
Sue Ann Forrest	NCMS
TJ Bugbee	NP
[illegible]	LGA
Loo Ann	herself
Katy Kingston	BP
Ryan Blackley	Conn Health I
Rick Zechini	Williams Mullen
Bill Scoggin	[illegible]
Rachel Beaulieu	[illegible] Law
Ashley Perkinson	Perkinson Law
Mike McBrien	Biogen
John Hardi	MFS
John McMillan	MFS

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 20, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Will Morgan	MFS
Peg Arnold	March of Dimes
C. Ann	Wakemed
C Hunt	NCHA

09-21-201

Senate Committee on Health Care
Wednesday, April 26, 2017 at 1:30 PM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Health Care met at 1:30pm on April 26, 2017, in Room 1027/1128 of the Legislative Building. Twelve Senate members were present.

Senator Joyce Krawiec presided.

Senator Krawiec opened the meeting by welcoming everyone and recognizing the Senate Sergeants-at-Arms—Terry Emondson, Steve McKaig and Sham Patel. She also recognized the Senate Pages in attendance—Derrin Mallory of Halifax County, Daniel Vaynshetyh of Mecklenburg County, and Kerrington Maggard of Brunswick County.

The only order of business was SB630. Senator Krawiec recognized Senator Hise to explain the bill. Senator Hise explained the bill and answered questions from the committee. Senator Lowe moved for a favorable report. The motion passed and the bill received a favorable report.

The meeting adjourned at 2:00 PM

Senator Joyce Krawiec
Presiding

Brian Mooney, Committee Clerk

Principal Clerk _____
Reading Clerk _____

Corrected #1: New Meeting Time and Location

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	April 26, 2017	1:30 PM	1027/1128 LB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 630	Revise IVC Laws to Improve Behavioral Health.	Senator Hise Senator Krawiec Senator Randleman

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

Senate Committee on Health Care
Wednesday, April 26, 2017, 1:30PM
1027/1128 Legislative Building

AGENDA

Senator Joyce Krawiec, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 630	Revise IVC Laws to Improve Behavioral Health.	Senator Hise Senator Krawiec Senator Randleman

Adjournment

SENATE BILL 630:
Revise IVC Laws to Improve Behavioral Health.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 26, 2017
Introduced by:	Sens. Hise, Krawiec, Randleman	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 630 would make changes to the laws on voluntary and involuntary commitment for the mentally ill and substance abusers contained in Chapter 122C (Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985).***

[As introduced, this bill was identical to H564, as introduced by Reps. Dobson, S. Martin, Lambeth, Malone, which is currently in House Health.]

CURRENT LAW and BILL ANALYSIS:

Section 1 would make the following definitional changes to Chapter 122C:

- Place the definition of "incapable" contained in G.S. 122C-72 in the definitions portion that applies to the whole of Chapter 122C and distinguishes it from the definition of "incompetent adult."
- Define the term "commitment examiner"
- Define the term "Outpatient treatment physician or center" to establish that LME/MCOs are not outpatient treatment or centers for purposes of outpatient commitment, but rather the LME/MCO's contracted service providers are the "outpatient treatment or center" that a court could order a person to treatment under the outpatient commitment statutes.
- Remove "program director" as a defined term.
- Modify definitions of "incompetent adult," "legally responsible person," and "local management entity."

Section 2 would clarify that when the phrase "client or legally responsible person" is used, and the client is an incapable adult who has not been adjudicated incompetent under Chapter 35A, the duty or right involved would be exercised not by the client, but by t a health care agent named pursuant to a valid health care power of attorney or by the client as expressed in a valid advance instruction for mental health treatment. If neither of these documents exist, the bill would specify who the legally responsible person for an incapable adult who has not been adjudicated incompetent would be.

Except for certain exceptions provided by statute, G.S. 122C-52 provides for the confidentiality of information acquired in attending or treating a client. Exceptions include upon order of a court of competent jurisdiction and for the purpose of filing a petition for involuntary commitment.

Section 3 would make technical changes to G.S. 122C-53 (exceptions to client's rights and confidentiality for the client's benefit) and allow facilities to disclose the time and location of a client's

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

admission or discharge to the client's next of kin when the responsible professional determines that such disclosure is in the best interest of the client.

Section 4 would mandate that in cases of clients voluntarily admitted or involuntary committed and facing district court hearings related to admission/discharge to mental health facilities, the client's counsel would receive copies of written results of examinations and other records without the client's consent. Section 4 would also allow an individual who has been a respondent in such a proceeding to get a copy of the court records of the proceeding upon submitting a written request to the clerk of court. The respondent's legally responsible person would have to exercise this right on behalf of the respondent if the respondent is a minor or incompetent adult at the time of the request.

Section 5 would clarify that, even though LME/MCOs (area authorities) are no longer treatment providers, they can continue to share confidential information with providers of behavioral health services ("facilities") and their own contracted providers ("area facilities") without client consent for purposes of coordinating the care and treatment of share clients.

Local Management Entities (LMEs) are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. The primary functions of an LME are designated in G.S. 122C-115.4(b) and must not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity.

Section 6 would add community crisis services planning as a primary function of LMEs under 122C-115.4(b).

Section 7 would make a technical change to conform with the change made in Section 8 of the bill.

Section 8 would require every LME/MCO to adopt a community crisis services plan to facilitate the implementation of the laws pertaining to involuntary commitment of the mentally ill and substance abusers within the LME/MCO's catchment area. Section 8 would set forth minimum requirements for the community crisis service plan and require the participation of law enforcement agencies, acute care hospitals, magistrates or clerks of court, area facilities with identified commitment examiners and other relevant community partners or stakeholders in the development of the plans.

Section 9 would make conforming and other changes to the laws governing the transfers of clients between 24-hour facilities. Substantive changes would require facilities to notify a client's legally responsible person fo the location of transfer and that the transfer is complete in cases where the client is a minor, incompetent adult, or individual with a health care power of attorney who is deemed incapable. This section also makes provisions for transfers between 24-hour facilities and acute care hospitals.

Section 10 would make modification to the law conferring immunity to facilities and facility officials, staff or employees to clarify the entities and persons who are immune. Section 10 would further update the standard required to receive immunity to require that a facility or person "take reasonable measures in good faith under the authority of this Article and is not grossly negligent."

Section 11 would make a conforming change in light of changes that would occur pursuant to Section 19 of the bill.

Generally, a person in need of treatment for mental illness or substance abuse may seek voluntary admission at any facility by presenting themselves for evaluation.

Section 12 would make changes to the laws governing voluntary admissions to clarify that a person's legally responsible person would have to sign an application for evaluation at a facility if the individual is a minor, incapable adult, or incompetent adult and require that information provided in an advance instruction for mental health treatment by the client be reviewed in the evaluation, if applicable. Section

12 would also repeal subsections (e), and (f1) of G.S. 122C-211 to conform with changes made in Section 14.

Section 13 would make conforming changes to the laws pertaining to discharges from facilities after voluntary admission.

Section 14 would add a new Part 2A to Article 5 of Chapter 122C entitled "Voluntary Admissions and Discharges; Incapable Adults; Facilities for Individuals with Mental Illness and Substance Use Disorder." These new laws would provide for the voluntary admission of "incapable adults" pursuant to an advance instruction for mental health treatment or the authority of a health care agent named in a valid health care power of attorney.

Section 15 would require applications for admission of minors in the case of voluntary admissions to facilities for the mentally ill and substance abusers to be in writing.

Section 16 would make a conforming change in light of the requirement imposed pursuant to Section 15 of the bill.

Section 17 would make a clarifying change to the laws dealing with voluntary admissions and discharges for incompetent adults to specify that those laws apply only to adults who are adjudicated incompetent, and not to "incapable adults" as defined by Section 1 of the bill.

When an incompetent adult is voluntarily admitted to a 24-hour facility where they will be subjected to the restrictions on freedom of movement, a hearing is required in the district court of the county in which the facility is located.

Section 18 would impose the following requirements pertaining to the judicial review of the voluntary admission of an incompetent adult:

- Prior to admission, the facility would be required to provide the incompetent adult and legally responsible person with written information on the procedures for the court review of the admission and the procedures for discharge.
- Within 24 hours after the admission, the facility would be required to notify the clerk of court that the incompetent adult has been admitted and that a hearing for concurrence in the admission must be scheduled. The notice would be required to include the names and addresses of the legally responsible persona nd responsible professional as well as a copy of the legally responsible person's written application for evaluation or admission and the facility's evaluation of the incompetent adult.
- After finding the statutory requirements have been met, the court may not set the length of the authorized admission for longer than 90 days.

Section 19 would make a number of changes to the statutes dealing with custody and transportation in situations where a person is being involuntarily committed. Section 19 would specify that transportation between counties for a first examination must be provided by the county where the respondent is taken into custody. The bill would authorize LME/MCOs, in addition to counties and cities, to designate personnel other than law enforcement to carry out parts of the custody and transportation process. The bill further clarifies the limitations and conditions on the use of force against a respondent and specifically exempts acute care hospitals and general hospitals when the use of force is governed by rules for accreditation by an accrediting body that reviews entities and individuals working there for compliance. Section 19 would also declare that the person designated to provide transportation for respondents in involuntary commitment situations must consent to being the designated person, or the agency that employs the person must consent.

Section 20 would make conforming changes to add "commitment examiner" to the persons who may treat respondents in involuntary commitment proceedings.

Section 21 would make a technical change.

Section 22 would make changes to the laws dealing with involuntary commitment proceedings when the person making an affidavit for involuntary commitment is a commitment examiner. Section 22 would provide for the electronic transmission of an affidavit to the court, and impose a requirement that the affiant document and file the examination findings with the affidavit, and impose requirements in instances where the commitment examiner is recommending outpatient treatment. Section 22 also would clarify that the examiner who performs a second examination pursuant to G.S. 122C-266 must not be the same commitment examiner who executed the affidavit and relieve commitment examiners and facilities and persons involved in the holding of a patient involuntarily pending a petition for, and issuance of, a custody order.

Section 23 would make changes to the laws pertaining to the special emergency procedures for individuals who need immediate hospitalization as a part of involuntary commitment proceedings. Section 23 would allow for temporary detention of a respondent if a 24-hour facility is not immediately available or appropriate to treat the respondent's condition. Section 23 would also provide for a procedure in instances where a commitment examiner finds a person meets the criteria for inpatient commitment, but does not require immediate e hospitalization to prevent harm to themselves or others.

Section 24 would amend the laws on the duties of law enforcement officers upon the initial examination of a respondent in an involuntary commitment. Without unnecessary delay after assuming custody, the individual providing transportation must take the respondent to an area facility identified by the LME/MCO in the community crisis plan for the respondent to be examined. If a facility identified in the plan or one of its commitment examiners is not available, or if there is no area facility identified in the plan, the transporter must take the respondent to an acute care hospital identified by the LME/MCO in the community crisis services plan. If no identified facility or acute care hospital is available, the transporter must take the respondent to any commitment examiner available in a private hospital or clinic, general hospital, or State facility for the mentally ill.

Section 24 would impose criteria for area facilities identified by LME/MCOs as sites for conducting initial examinations and provide that the responsible professional at a site of first examination may transfer a respondent to an acute care hospital. In cases where the commitment examiner finds that the respondent is mentally ill and a danger to self or others, Section 24 would impose a requirement that the transporter take the respondent to a 24-hour facility within 6 hours. Currently, in cases where a 24-hour facility is not available, a respondent may be temporarily restrained for up to seven days while waiting for a facility to become available. Section 24 would expressly provide that a commitment examiner could initiate a new involuntary commitment proceeding prior to the expiration of the seven day period, if the respondent meets the applicable criteria.

Finally, rather than require a commitment examiner to provide a respondent for whom outpatient treatment is recommended directing the respondent to appear for treatment, Section 24 would require the commitment examiner to notify the LME/MCO that the respondent is being recommended for outpatient treatment. The LME/MCO would then be responsible for scheduling an appointment with the center and provide contact information for the center. The commitment examiner would then be required to provide the respondent with information on the center and notify the outpatient treatment center and send a copy of their examination report to the center.

Section 25 would acknowledge that physicians and eligible psychologists are qualified to perform the commitment examinations required for involuntary commitment for the mentally ill and substance

abusers. The bill would then eliminate the ability of the Secretary of DHHS to waive certain requirements pertaining to the first examinations of respondents by commitment examiners, and instead allow the Secretary to individually certify an expanded list of professionals, including licensed professional counselors, nurse practitioners, and physicians assistants, to perform first commitment examinations. The bill would allow for these certifications to be renewed every three years upon completion of a refresher training program approved by the Department. The requirement that the LME document the availability of a physician to provide backup support would be repealed, and the Department would be required to submit a list of certified first commitment examiners to the Chief District Court Judge of each judicial district and maintain a current list of certified first commitment examiners on its website.

Sections 26 and 27 would make conforming changes.

Section 28 would add a requirement for the physician who performs the required examination upon a respondent's arrival at a 24-hour facility as part of an involuntary commitment proceeding. If a physician finds that the respondent meets the criteria for outpatient commitment and release from the facility pending a hearing, the physician who performed the examination would be required to contact the LME/MCO that serves the county in which the respondent resides to inform them that the respondent is being recommended for outpatient commitment. The LME/MCO would then be required to identify and schedule an appointment with a proposed outpatient treatment center and provide the commitment examiner with the name, address and phone number of the center and the date and time of the scheduled appointment.

Section 29 would make a conforming change.

Section 30 would amend the statutes pertaining to district court hearings for inpatient commitment to impose a requirement that respondents who are temporarily detained and subject to a series of successive custody orders be given a hearing within 10 days of the day the respondent is taken into custody under the most recent custody order. Section 30 also makes provisions for hearings to be held by audio and video transmission between the treatment facility and courtroom provided certain requirements are met.

Section 31 would amend the laws that set forth the dispositions a district court can make after hearings in involuntary commitment matters to impose requirements on courts ordering outpatient commitment. When a respondent is being held at 24-hour facility pending a district court hearing based on the facility's finding that the respondent is dangerous to self or others and recommended for inpatient commitment, before the court releases such a respondent under an order of outpatient commitment, Section 31 requires the 24-hour facility to identify for the court an available outpatient treatment provider that has participated in discharge planning and scheduled an outpatient appointment for the respondent.

Section 32 would make a conforming change.

Section 33 would amend the laws pertaining to affidavits for involuntary commitment of substance abusers when the affiant is a commitment examiner to bring substance abuse involuntary commitments in line with those for the mentally ill. Section 33 would include a release of civil and criminal liability similar to that added for mentally ill treatment providers in Section 22 for facilities and their employees provided that they were acting in accordance with statute.

Section 34 would make conforming changes.

Section 35 would amend the laws on the duties of law enforcement officers upon the initial examination of a respondent in an involuntary commitment for substance abuse to reflect the changes made in

Section 24 of the bill pertaining to the duties of law enforcement officers in the context of involuntary commitments for the mentally ill.

Section 36 would make technical changes.

Section 37 would make technical and conforming changes to the statutes pertaining to second examinations for the commitment of substance abusers and would require the findings of the second examiner, along with the facts upon which the findings are based, to be sent to the clerk of superior court.

Section 38 would amend the statutes pertaining to district court hearings for commitment for substance abusers to impose a requirement that respondents who are temporarily detained and subject to a series of successive custody orders be given a hearing within 10 days of the day the respondent is taken into custody under the most recent custody order. The bill would also provide for the respondent to waive the requirement that he or she be personally present for the hearing and for the use of audio video technology to conduct hearings similar to that provided for in Section 30 of the bill.

Section 39 would amend the law on dispositions in cases where courts order commitment of substance abuser respondents to impose the same requirements Section 31 imposes on courts ordering outpatient commitment for mentally ill respondents.

Sections 40-44 would make technical and conforming changes.

Section 45 would require each LME/MCO to submit to the Department of Health and Human Services a copy of its current community crisis services plan as would be required under this bill by the earlier of (i) 12 months after the date the Department receives notification that the federal Centers for Medicaid and Medicare has approved all necessary waivers and State Plan amendments for Medicaid and NC Health Choice transformation, or (ii) six months prior to the date the Department actually initiates capitated contracts with Prepaid Health Plans for the delivery of Medicaid and NC Health Choice services.

EFFECTIVE DATE: Section 45 would become effective when it becomes law. The remainder would become effective December 1, 2017, and apply to proceedings initiated on or after that date.

**UNC School of Government Attorney Mark F. Botts contributed substantially in the preparation of this summary*

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

S 1

SENATE BILL 630*

Short Title:	Revise IVC Laws to Improve Behavioral Health.	(Public)
Sponsors:	Senators Hise, Krawiec, Randleman (Primary Sponsors); Cook, Tucker, and Woodard.	
Referred to:	Rules and Operations of the Senate	

April 5, 2017

A BILL TO BE ENTITLED

AN ACT REVISING THE LAWS PERTAINING TO INVOLUNTARY COMMITMENT IN ORDER TO IMPROVE THE DELIVERY OF BEHAVIORAL HEALTH SERVICES IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

...

(8a) "Commitment examiner" means a physician, an eligible psychologist, or any health professional or mental health professional who is certified under G.S. 122C-263.1 to perform the first examination for involuntary commitment described in G.S. 122C-263(c) or G.S. 122C-283(c) as required by Parts 7 and 8 of this Article.

...

(16a) "Incapable" with respect to an individual means in the opinion of a physician or eligible psychologist, the individual currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. An adult individual who is incapable is not the same as an incompetent adult unless the adult individual has been adjudicated incompetent under Chapter 35A of the General Statutes.

(17) "Incompetent adult" means an adult individual who has been adjudicated ~~incompetent.~~incompetent under Chapter 35A of the General Statutes.

...

(20) "Legally responsible person" means: (i) when applied to an adult, who has been adjudicated incompetent, a guardian; (ii) when applied to a minor, a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment; or (iii) when applied to an adult who is incapable as defined in G.S. 122C-72(c) and who has not been adjudicated incompetent, a health care agent named pursuant to a valid health care power of ~~attorney.~~attorney; provided, however, that if an incapable adult does not have a health care agent or guardian, "legally responsible person" means one of the persons specified in

subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority indicated in said subdivisions (3) through (7).

...

(20b) "Local management entity" or "LME" means an ~~area authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.~~area authority.

...

(27a) "Outpatient treatment physician or center" as used in Part 7 of Article 5 of this Chapter means a physician or center that provides treatment services directly to the outpatient commitment respondent. An LME/MCO that contracts with an outpatient treatment physician or center to provide outpatient treatment services to a respondent is not an outpatient treatment physician or center. Every LME/MCO is responsible for contracting with qualified providers of services in accordance with G.S. 122C-141, 122C-142(a), 122C-115.2(b)(1)b., and 122C-115.4(b)(2) to ensure the availability of qualified providers of outpatient commitment services to clients of LME/MCOs who are respondents to outpatient commitment proceedings and meet the criteria for outpatient commitment. An LME/MCO provider shall not be designated as an outpatient treatment physician or center on an outpatient commitment order unless the respondent is a client of an LME/MCO or is eligible for services through an LME/MCO, or the respondent otherwise qualifies for the provision of services offered by the provider.

...

~~(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.~~

...."

SECTION 2. G.S. 122C-4 reads as rewritten:

"**§ 122C-4. Use of phrase "client or ~~his~~ the legally responsible person."**

(a) Except as otherwise provided by law, whenever in this Chapter the phrase "client or ~~his~~ the legally responsible person" is used, and the client is a minor or an incompetent adult, the duty or right involved shall be exercised not by the client, but by the legally responsible person.

(b) Except as otherwise provided by law, whenever in this Chapter the phrase "client or the legally responsible person" is used, and the client is an incapable adult who has not been adjudicated incompetent under Chapter 35A of the General Statutes, the duty or right involved shall be exercised not by the client but by a health care agent named pursuant to a valid health care power of attorney, if one exists, or by the client as expressed in a valid advance instruction for mental health treatment, if one exists. If no health care power of attorney or advance instruction for mental health treatment exists, the legally responsible person for an incapable adult who has not been adjudicated incompetent under Chapter 35A of the General Statutes shall be one of the persons listed in subdivisions (3) through (7) of subsection (c) of G.S. 90-21.13, to be selected based on the priority order indicated in said subdivisions (3) through (7)."

SECTION 3. G.S. 122C-53 reads as rewritten:

"**§ 122C-53. Exceptions; client.**

(a) A facility may disclose confidential information if the client or ~~his~~ the legally responsible person consents in writing to the release of the information to a specified person. This release is valid for a specified length of time and is subject to revocation by the consenting individual.

(b) A facility may disclose (i) the fact of admission or discharge of a client and (ii) the time and location of the admission or discharge to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

(c) Upon request a client shall have access to confidential information in ~~his client~~ the client's record except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or ~~his~~ the facility director's designee. If the attending physician or, if there is none, the facility director or ~~his~~ the facility director's designee has refused to provide confidential information to a client, the client may request that the information be sent to a physician or psychologist of the client's choice, and in this event the information shall be so provided.

(d) Except as provided by G.S. 90-21.4(b), upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending physician or, if there is none, by the facility director or ~~his~~ the facility director's designee. If the attending physician or, if there is none, the facility director or ~~his~~ the facility director's designee has refused to provide confidential information to the legally responsible person, the legally responsible person may request that the information be sent to a physician or psychologist of the legally responsible person's choice, and in this event the information shall be so provided.

(e) A client advocate's access to confidential information and ~~his~~ the client's responsibility for safeguarding this information are as provided by subsection (g) of this section.

(f) As used in subsection (g) of this section, the following terms have the meanings specified:

(1) "Internal client advocate" means a client advocate who is employed by the facility or has a written contractual agreement with the Department or with the facility to provide monitoring and advocacy services to clients in the facility in which the client is receiving ~~services; and~~services.

(2) "External client advocate" means a client advocate acting on behalf of a particular client with the written consent and ~~authorization;~~authorization under either of the following circumstances:

a. In the case of a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, of the ~~client; or~~client.

b. In the case of any other client, of the client and ~~his~~ the legally responsible person.

(g) An internal client advocate shall be granted, without the consent of the client or ~~his~~ the legally responsible person, access to routine reports and other confidential information necessary to fulfill ~~his~~ monitoring and advocacy functions. In this role, the internal client advocate may disclose confidential information received to the client involved, to his or her legally responsible person, to the director of the facility or ~~his~~ the director's designee, to other individuals within the facility who are involved in the treatment or habilitation of the client, or to the Secretary in accordance with the rules of the Commission. Any further disclosure shall require the written consent of the client and ~~his~~ the legally responsible person. An external client advocate shall have access to confidential information only upon the written consent of the client and ~~his~~ the legally responsible person. In this role, the external client advocate may use the information only as authorized by the client and ~~his~~ the legally responsible person.

(h) In accordance with G.S. 122C-205, the facility shall notify the appropriate individuals upon the escape from and subsequent return of clients to a 24-hour facility.

(i) Upon the request of (i) a client who is an adult and who has not been adjudicated incompetent under Chapter 35A or former Chapters 33 or 35 of the General Statutes, or (ii) the

legally responsible person for any other client, a facility shall disclose to an attorney confidential information relating to that client."

SECTION 4. G.S. 122C-54 reads as rewritten:

"**§ 122C-54. Exceptions; abuse reports and court proceedings.**

...

(a1) Upon a determination by the facility director or ~~his~~ the facility director's designee that disclosure is in the best interests of the client, a facility may disclose confidential information for purposes of filing a petition for involuntary commitment of a client pursuant to Article 5 of this Chapter or for purposes of filing a petition for the adjudication of incompetency of the client and the appointment of a guardian or an interim guardian under Chapter 35A of the General Statutes.

...

(c) Certified copies of written results of examinations by physicians and other medical and court records in the cases of clients voluntarily admitted or involuntarily committed and facing district court hearings and rehearings pursuant to Article 5 of this Chapter shall be furnished by the facility to the client's counsel, the attorney representing the State's interest, and the court. Notwithstanding the confidentiality of these records, the client's counsel shall have access to any medical and court records the client's counsel deems relevant to the court proceeding and shall not be required to obtain the client's consent in order to access these records. The confidentiality of client information shall be preserved in all matters except those pertaining to the necessity for admission or continued stay in the facility or commitment under review. ~~The relevance of confidential information for which disclosure is sought in a particular case shall be determined by the court with jurisdiction over the matter.~~

(d) Any individual seeking confidential information contained in the court files or the court records of a proceeding made pursuant to Article 5 of this ~~Chapter~~ Chapter, except for the respondent, may file a written motion in the cause setting out why the information is needed. A district court judge may issue an order to disclose the confidential information sought if ~~he~~ the judge finds (i) the order is appropriate under the circumstances and ~~if he finds that~~(ii) it is in the best interest of the individual admitted or committed or of the public to have the information disclosed. An individual who is or has been a respondent in a proceeding pursuant to Article 5 of this Chapter shall be provided the court records of the proceeding upon submitting a written request to the clerk of superior court in the county in which the proceeding is pending. The clerk of court shall take reasonable and appropriate measures to verify the identity of the individual making the request. The respondent's legally responsible person shall exercise the respondent's right to access the court records if the respondent is a minor or an incompetent adult at the time of the request.

...

(e) Upon the request of the legally responsible person or the minor admitted or committed, and after that minor has both been released and reached adulthood, the court records of that minor made in proceedings pursuant to Article 5 of this Chapter may be expunged from the files of the court. The minor and ~~his~~ the minor's legally responsible person shall be informed in writing by the court of the right provided by this subsection at the time that the application for admission is filed with the court.

...

(g) A facility may disclose confidential information to an attorney who represents either the facility or an employee of the facility, if such information is relevant to litigation, to the operations of the facility, or to the provision of services by the facility. An employee may discuss confidential information with ~~his~~ the employee's attorney or with an attorney representing the facility in which ~~he~~ the employee is employed.

...."

SECTION 5. G.S. 122C-55 reads as rewritten:

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

(a) Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. For the purposes of this section, ~~coordinate~~ the following definitions apply:

(1) "Coordinate" means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services by one or more facilities and includes the referral of a client from one facility to another.

(2) "Facility" and "area facility" include an area authority.

(3) "Secretary" includes the Community Care of North Carolina Program, or other primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.

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

...."

SECTION 6. G.S. 122C-115.4(b) is amended by adding a new subdivision to read:

"(7a) Community crisis services planning in accordance with G.S. 122C-202.2."

SECTION 7. G.S. 122C-117(a)(14) reads as rewritten:

"(14) Maintain a 24-hour a day, seven day a week crisis response ~~service.~~service and adopt a community crisis services plan in accordance with G.S. 122C-202.2. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers and shall be initiated within one hour of notification. Crisis services do not require prior authorization but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety."

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

"**§ 122C-202.2. LME/MCO community crisis services plan; commitment examiners; transporting agencies; training; collaboration.**

(a) Every LME/MCO shall adopt a community crisis services plan developed in accordance with this section to facilitate the implementation of Parts 7 and 8 of this Article within its catchment area. The community crisis services plan for the LME/MCO's catchment

area shall be comprised of separate plans, known as "local area crisis services plans" or "local plans," for each of the local areas or regions within the catchment area that the LME/MCO identifies as an appropriate local planning area, taking into consideration the available resources and interested stakeholders within a particular geographic area or region of the catchment area. Each LME/MCO may determine the number and geographic boundaries of the local planning areas within its catchment area. Each local area crisis services plan shall, for the local area covered by the local plan, do at least all of the following:

(1) Identify one or more area facilities where a respondent subject to a transportation and custody order must be taken for a first examination by a commitment examiner as required by G.S. 122C-263(a) and G.S. 122C-283(a). If an area facility is identified in the plan as an appropriate facility for conducting the first examination for commitment, law enforcement officers, and any persons designated to provide transportation and custody under G.S. 122C-251(g), shall transport the commitment respondent to the area facility in accordance with, and under circumstances addressed in, the local area crisis services plan. If no area facility is available in the local planning area to conduct the first examination for commitment, the local plan shall identify an acute care hospital or hospitals or other location for first examination. This subdivision applies when a magistrate or clerk of court orders a respondent to be taken into custody for examination by a commitment examiner. This subdivision does not apply when the respondent is already present on the premises of a location and the first examiner at that location is the affiant who is petitioning to initiate the commitment process.

(2) Identify any persons that the LME/MCO has designated under G.S. 122C-251(g) to be responsible for all or part of the transportation and custody of respondents in involuntary commitment proceedings under this Article, to the extent that the LME/MCO has exercised its authority under G.S. 122C-251(g). Any plan adopted by an LME/MCO under G.S. 122C-251(g) shall be included as a part of the local area crisis services plan for the area to which it pertains. Counties and cities shall retain the responsibilities for custody and transportation set forth in this Article except as otherwise set forth in a plan developed and adopted pursuant G.S. 122C-251(g).

(3) Identify appropriate and available training for law enforcement personnel, and any persons designated under G.S. 122C-251(g), who provide transportation and custody of involuntary commitment respondents. To the extent feasible, law enforcement officers shall participate in the training program identified by the LME/MCO. Persons who are designated under G.S. 122C-251(g) to provide all or part of the transportation and custody required for involuntary commitment proceedings under this Article and who are not law enforcement officers shall participate in the training. To the extent feasible, the identified training shall address the use of de-escalation strategies and techniques, the safe use of force and restraint, respondent rights relevant to custody and transportation, the location of any area facilities identified by the LME/MCO pursuant to subdivision (1) of this subsection, and the completion and return of the custody order to the clerk of superior court. The training identified by the LME/MCO may be comprised of one or more programs, and may include a crisis intervention team program or other mental health training program or a combination of these programs. To the extent feasible, the LME/MCO shall identify training that

includes a component for dialogue with consumers of mental health, developmental disabilities, and substance abuse services.

(b) Law enforcement agencies, acute care hospitals, magistrates or clerks of court, area facilities with identified commitment examiners, the LME/MCO, and other relevant community partners or stakeholders shall participate in the development of the local area crisis services plans described in this section.

(c) The plans adopted under this section may address any matters necessary to facilitate the custody, transportation, examination, and treatment of respondents to commitment proceedings under Parts 7 and 8 of this Article."

SECTION 9. G.S. 122C-206 reads as rewritten:

"**§ 122C-206. Transfers of clients between 24-hour ~~facilities.~~facilities; transfer of clients from 24-hour facilities to acute care hospitals.**

(a) Before transferring a voluntary adult client from one 24-hour facility to another, the responsible professional at the original facility shall: (i) get authorization from the receiving facility that the facility will admit the client; (ii) get consent from the client; and (iii) if consent to share information is granted by the ~~client,~~client or if disclosure of the information is permitted under G.S. 122C-53(b), notify the next of kin of the time and location of the transfer. The preceding requirements of this paragraph may be waived if the client has been admitted under emergency procedures to a State facility not serving the client's region of the State. Following an emergency admission, the client may be transferred to the appropriate State facility without consent according to the rules of the Commission.

(b) Before transferring a respondent held for a district court hearing or a committed respondent from one 24-hour facility to another, the responsible professional at the original facility shall:

(1) Obtain authorization from the receiving facility that the facility will admit the respondent; and

(2) Provide reasonable notice to the ~~respondent, or~~ respondent or the legally responsible person, and to the respondent's counsel, of the reason for the transfer and document the notice in the client's record.

No later ~~that~~ than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, the respondent's counsel, and, if consent is granted by the ~~respondent,~~ respondent or disclosure of the information is permitted under G.S. 122C-53(b), the next of kin, that the transfer is ~~completed.~~complete. If the transfer is completed before the judicial commitment hearing, these proceedings shall be initiated by the receiving facility. If the respondent is a minor, an incompetent adult, or an individual with a health care power of attorney who is deemed incapable, then the responsible professional at the original facility shall, not later than 24 hours after the transfer, notify the client's legally responsible person of the location of the transfer and that the transfer is complete.

(c) Minors and incompetent adults, admitted pursuant to Parts 3 and 4 of this Article, may be transferred from one 24-hour facility to another following the same procedures specified in subsection (b) of this section. In addition, the legally responsible person shall be consulted before the proposed ~~transfer.~~transfer and notified, within 24 hours after the transfer is complete, of the location of the transfer and that the transfer is complete. If the transfer is completed before the judicial determination required in G.S. 122C-223 or G.S. 122C-232, these proceedings shall be initiated by the receiving facility.

(c1) If a client described in subsections (b) or (c) of this section is to be transferred from one 24-hour facility to ~~another~~ another, or to an acute care hospital pursuant to subsection (e) of this section, and transportation is needed, the responsible professional at the original facility shall notify the clerk of court or magistrate, and the clerk of court or magistrate shall issue a custody order for transportation of the client as provided by G.S. 122C-251.

(d) Minors and incompetent adults, admitted pursuant to Part 5 of this Article and incapable adults admitted pursuant to Part 2A of this Article, may be transferred from one 24-hour facility to another provided that prior to transfer the responsible professional at the original facility shall:

(1) Obtain authorization from the receiving facility that the facility will admit the client; and

(2) Provide reasonable notice to the client regarding the reason for transfer and document the notice in the client's record; and

(3) Provide reasonable notice to and consult with the legally responsible person regarding the reason for the transfer and document the notice and consultation in the client's record.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the legally responsible person that the transfer is completed.

(e) The responsible professional may transfer a client from one 24-hour facility to another or to an acute care hospital for emergency medical treatment, emergency medical evaluation, or emergency surgery without notice to or consent from the client. Within a reasonable period of time the responsible professional shall notify the next of kin or the legally responsible person of the client of the time and location of the transfer.

(f) When a client is transferred from one 24-hour facility to another ~~facility~~ solely for medical reasons, the client shall be returned to the original facility when the medical care is completed unless the responsible professionals at both facilities concur that discharge of the client who is not subject to G.S. 122C-266(b) is appropriate.

(f1) When a client is transferred from a 24-hour facility to an acute care hospital solely for medical reasons, the hospital shall return the client to the original facility as soon as the next client space becomes available at the original facility after completion of the client's medical care, and the original facility must accept the return of the client; provided, however, that if the responsible professionals at both facilities concur that discharge of a client who is not subject to G.S. 122C-266(b) is appropriate, the client shall be released. If, at the time of the transfer, a client is being held under a custody order pending a second commitment examination or a district court hearing under involuntary commitment proceedings, the custody order shall remain valid throughout the period of time necessary to complete the client's medical care and transport the client between the 24-hour facility and the acute care hospital; provided, however, that the requirement for a timely hearing under G.S. 122C-268(a) applies. Any decision to terminate the proceedings because the respondent no longer meets the criteria for commitment or because a hearing cannot be held within the time required by G.S. 122C-268(a) shall be documented and reported to the clerk of superior court in accordance with G.S. 122C-266(c).

(g) The Commission may adopt rules to implement this section."

SECTION 10. G.S. 122C-210.1 reads as rewritten:

"**§ 122C-210.1. Immunity from liability.**

No ~~facility~~ facility, including an area facility, a facility licensed under this Chapter, an acute care hospital, a general hospital, or an area authority, LME, or LME/MCO, or any of its officials, staff, or employees, or any physician or other individual who is responsible for the custody, transportation, examination, management, supervision, treatment, or release of a client and who ~~follows accepted professional judgment, practice, and standards~~ takes reasonable measures in good faith under the authority of this Article and is not grossly negligent is civilly or criminally liable, personally or otherwise, for actions arising from these responsibilities or for actions of the client. This immunity is in addition to any other legal immunity from liability to which these ~~facilities~~ facilities, agencies, or individuals may be entitled and applies to actions performed in connection with, or arising out of, the ~~admission~~ custody, transportation, examination, admission, or commitment of any individual pursuant to this Article."

SECTION 11. G.S. 122C-210.3 reads as rewritten:

"**§ 122C-210.3. Electronic and facsimile transmission of custody orders.**

A custody order entered by the clerk or magistrate pursuant to this Chapter may be delivered to the law enforcement officer or other person designated under G.S. 122C-251(g) by electronic or facsimile transmission."

SECTION 12. G.S. 122C-211 reads as rewritten:

"**§ 122C-211. Admissions.**

(a) Except as provided in subsections (b) through (f1) of this section, any individual, including a parent in a family unit, in need of treatment for mental illness or substance abuse may seek voluntary admission at any facility by presenting himself or herself for evaluation to the facility. No physician's statement is necessary, but a written application for evaluation or admission, signed by the individual seeking ~~admission,~~ admission or the individual's legally responsible person, is required. The application form shall be available at all times at all facilities. However, no one shall be denied admission because application forms are not available. An evaluation shall determine whether the individual is in need of care, treatment, habilitation or rehabilitation for mental illness or substance abuse or further evaluation by the facility. Information provided by family members regarding the individual's need for treatment shall be reviewed in the evaluation. If applicable, information provided in an advance instruction for mental health treatment by the client or the client's legally responsible person shall be reviewed in the evaluation. An individual may not be accepted as a client if the facility determines that the individual does not need or cannot benefit from the care, treatment, habilitation, or rehabilitation available and that the individual is not in need of further evaluation by the facility. The facility shall give to an individual who is denied admission a referral to another facility or facilities that may be able to provide the treatment needed by the client.

(b) In 24-hour facilities the application shall acknowledge that the applicant may be held by the facility for a period of 72 hours after any written request for release that the applicant may make, and shall acknowledge that the 24-hour facility may have the legal right to petition for involuntary commitment of the applicant during that period. At the time of application, the facility shall tell the applicant about procedures for discharge.

(c) Any individual who voluntarily seeks admission to a 24-hour facility in which medical care is an integral component of the treatment shall be examined and evaluated by a physician of the facility within 24 hours of admission. The evaluation shall determine whether the individual is in need of treatment for mental illness or substance abuse or further evaluation by the facility. If the evaluating physician determines that the individual will not benefit from the treatment available, the individual shall not be accepted as a client.

(d) Any individual who voluntarily seeks admission to any 24-hour facility, other than one in which medical care is an integral component of the treatment, shall have a medical examination within 30 days before or after admission if it is reasonably expected that the individual will receive treatment for more than 30 days or shall produce a current, valid physical examination report, signed by a physician, completed within 12 months prior to the current admission. When applicable, this examination may be included in an examination conducted to meet the requirements of G.S. 122C-223 or G.S. 122C-232.

~~(e) When an individual from a single portal area seeks admission to an area or State 24-hour facility, the admission shall follow the procedures as prescribed in the area plan. When an individual from a single portal area presents himself for admission to the facility directly and is in need of an emergency admission, the individual may be accepted for admission. The facility shall notify the area authority within 24 hours of the admission. Further planning of treatment for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.~~

(f) A family unit may voluntarily seek admission to a 24-hour substance abuse facility that is able to provide, directly or by contract, treatment, habilitation, or rehabilitation services

that will specifically address the family unit's needs. These services shall include gender-specific substance abuse treatment, habilitation, or rehabilitation for the parent as well as assessment, well-child care, and, as needed, early intervention services for the child. A family unit that voluntarily seeks admission to a 24-hour substance abuse facility shall be evaluated by the facility to determine whether the family unit would benefit from the services of the facility. A facility shall not accept a family unit as a client if the facility determines that the family unit does not need or cannot benefit from the care, habilitation, or rehabilitation available at the facility. The facility shall give to a family unit that is denied admission a referral to another facility or facilities that may be able to provide treatment needed by the family unit. Except as otherwise provided, this section applies to a parent in a family unit seeking admission under this section.

~~(f1) An individual in need of treatment for mental illness may be admitted to a facility pursuant to an advance instruction for mental health treatment or pursuant to the authority of a health care agent named in a valid health care power of attorney, provided that the individual is incapable, as defined in G.S. 122C-72(4) at the time of the need for admission. An individual admitted to a facility pursuant to an advance instruction for mental health treatment may not be retained for more than 10 days, except as provided for in subsection (b) of this section. When a health care power of attorney authorizes a health care agent to seek the admission of an incapable individual, the health care agent shall act for the individual in applying for admission to a facility and in consenting to medical treatment at the facility when consent is required, provided that the individual is incapable.~~

(g) As used in this Part, the term "family unit" means a parent and the parent's dependent children under the age of three years."

SECTION 13. G.S. 122C-212 reads as rewritten:

"**§ 122C-212. Discharges.**

(a) Except as provided in ~~subsections~~ subsection (b) ~~and (c)~~ of this section, an individual who has been voluntarily admitted to a facility shall be discharged upon his or her own request. A request for discharge from a 24-hour facility shall be in writing.

(b) An individual who has been voluntarily admitted to a 24-hour facility may be held for 72 hours after his or her written application for discharge is submitted.

~~(c) When an individual from a single portal area who has been voluntarily admitted to an area or State 24-hour facility is discharged, the discharge shall follow the procedures as prescribed in the area plan.~~"

SECTION 14. Article 5 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 2A. Voluntary Admissions and Discharges; Incapable Adults; Facilities for Individuals With Mental Illness and Substance Use Disorder.

"**§ 122C-213. Voluntary admission of individuals determined to be incapable.**

(a) An individual in need of treatment for mental illness and who is incapable, as defined in G.S. 122C-3 and G.S. 122C-72, may be admitted to and treated in a facility pursuant to an advance instruction for mental health treatment executed in accordance with Part 2 of Article 3 of this Chapter or pursuant to the authority of a health care agent named in a valid health care power of attorney executed in accordance with Article 3 of Chapter 32A of the General Statutes.

(b) Except as otherwise provided in this Part, G.S. 122C-211 applies to admissions of incapable adults under this Part.

(c) An individual making an advance instruction for mental health treatment may grant or withhold consent for mental health treatment, including the use of psychotropic medication, electroconvulsive treatment, and admission to and retention in a 24-hour facility for mental illness. An attending physician or other mental health treatment provider shall act in accordance with an advance instruction for mental health treatment upon a determination that the

individual making the advance instruction is incapable, in which case, the provisions of Part 2 of Article 3 of this Chapter apply.

(d) When a health care power of attorney authorizes a health care agent pursuant to G.S. 32A-19 to make mental health treatment decisions for an incapable individual, the health care agent shall act for the individual in applying for admission and consenting to treatment at a facility, consistent with the extent and limitations of authority granted in the health care power of attorney for as long as the individual remains incapable.

(e) A 24-hour facility may not hold an individual who is determined to be incapable at the time of admission and who is admitted pursuant to an advance instruction for mental health treatment for more than 15 days, except as provided in G.S. 122C-211(b); provided, however, that an individual who regains sufficient understanding and capacity to make and communicate mental health treatment decisions may elect to continue his or her admission and treatment pursuant to the individual's informed consent in accordance with G.S. 122C-211.

"**§ 122C-214. Discharge of individuals determined to be incapable.**

(a) The responsible professional shall unconditionally discharge an individual admitted to a facility pursuant to this Part at any time it is determined that the individual is no longer mentally ill or in need of treatment at the facility.

(b) An individual who has been voluntarily admitted to a facility pursuant to this Part and who is no longer deemed incapable shall be discharged upon his or her own request. An individual's request for discharge from a 24-hour facility shall be in writing. A facility may hold an individual who has been voluntarily admitted to a 24-hour facility pursuant to this Part for up to 72 hours after the individual submits a written request for discharge, but the facility shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(c) A health care agent named in a valid health care power of attorney may submit on behalf of an individual admitted to a facility under this Part a written request to have the individual discharged from the facility, provided (i) the individual remains incapable at the time of the request and (ii) the request is consistent with the authority expressed in the health care power of attorney. A facility may hold an individual for up to 72 hours after a health care agent submits a written request for the individual's discharge but shall release the individual upon the expiration of 72 hours following submission of the written request for discharge unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(d) If, in the opinion of a physician or eligible psychologist, an individual admitted to a facility under this Part regains sufficient understanding and capacity to make and communicate mental health treatment decisions while in treatment, and the individual refuses to sign an authorization for continued treatment within 72 hours after regaining decisional capacity, the facility shall discharge the individual unless the responsible professional obtains an order under Part 7 or 8 of this Article to hold the client.

(e) In any case in which an order is issued authorizing the involuntary commitment of an individual admitted to a facility under this Part, the facility's further treatment and holding of the individual shall be in accordance with Part 7 or 8 of this Article, whichever is applicable.

"**§§ 122C-215 through 122C-220: Reserved for future codification purposes.**"

SECTION 15. G.S. 122C-221(a) reads as rewritten:

"(a) Except as otherwise provided in this Part, a minor may be admitted to a facility if the minor is mentally ill or a substance abuser and in need of treatment. Except as otherwise provided in this Part, the provisions of G.S. 122C-211 shall apply to admissions of minors under this Part. Except as provided in G.S. 90-21.5, in applying for admission to a facility, in consenting to medical treatment when consent is required, and in any other legal procedure under this Article, the legally responsible person shall act for the minor. The application for admission of the minor shall be in writing and signed by the legally responsible person. If a

minor reaches the age of 18 while in treatment under this Part, further treatment is authorized only on the written authorization of the client or under the provisions of Part 7 or Part 8 of Article 5 of this Chapter."

SECTION 16. G.S. 122C-224(c) reads as rewritten:

"(c) Within 24 hours after admission, the facility shall notify the clerk of court in the county where the facility is located that the minor has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time notice is given to schedule a hearing, the facility shall (i) notify the clerk of the names and addresses of the legally responsible person and the responsible ~~professional.~~professional and (ii) provide the clerk with a copy of the legally responsible person's written application for admission of the minor and the facility's written evaluation of the minor, both of which are required under G.S. 122C-211(a)."

SECTION 17. Part 4 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-230. Applicability of Part 4.**

This Part applies to adults who are adjudicated incompetent by a court of competent jurisdiction. This Part does not apply to the admission of adults who are deemed incapable but who have not been adjudicated incompetent."

SECTION 18. G.S. 122C-232 reads as rewritten:

"**§ 122C-232. Judicial determination.**

(a) When an incompetent adult is admitted to a 24-hour facility where the incompetent adult will be subjected to the same restrictions on ~~his~~ freedom of movement present in the State facilities for the mentally ill, or to similar restrictions, a hearing shall be held in the district court in the county in which the 24-hour facility is located within 10 days ~~of~~ after the day ~~that~~ the incompetent adult is admitted to the facility. A continuance of not more than five days may be granted upon motion ~~of:~~any of the following:

(1) The ~~court;~~court.

(2) Respondent's ~~counsel; or~~counsel.

(3) The responsible professional.

The Commission shall adopt rules governing procedures for admission to other 24-hour facilities not falling within the category of facilities where freedom of movement is restricted; these rules shall be designed to ensure that no incompetent adult is improperly admitted to or remains in a facility.

(a1) Prior to admission, the facility shall provide the incompetent adult and the legally responsible person with written information describing the procedures for court review of the admission and the procedures for discharge.

(a2) Within 24 hours after admission, the facility shall notify the clerk of court of the county in which the facility is located that the incompetent adult has been admitted and that a hearing for concurrence in the admission must be scheduled. At the time the facility provides notice to the court to schedule a hearing for concurrence, the facility shall notify the clerk of the names and addresses of the legally responsible person and the responsible professional and provide a copy of the legally responsible person's written application for evaluation or admission of the incompetent adult and the facility's evaluation of the incompetent adult.

(b) In any case requiring the hearing described in subsection (a) of this section, no petition is necessary; the written application for voluntary admission shall serve as the initiating document for the hearing. The court shall determine whether the incompetent adult is mentally ill or a substance abuser and is in need of further treatment at the facility. Further treatment at the facility should be undertaken only when lesser measures will be insufficient. If the court finds by clear, cogent, and convincing evidence that these requirements have been met, the court shall concur with the voluntary admission of the incompetent adult and set the length of the authorized admission for a period not to exceed 90 days. If the court finds that these requirements have not been met, it shall order that the incompetent adult be released. A finding

of dangerousness to self or others is not necessary to support the determination that further treatment should be undertaken.

(c) Unless otherwise provided in this Part, the hearing specified in subsection (a) of this section, including the provisions for representation of indigent incompetent adults, all subsequent proceedings, and conditional release are governed by the involuntary commitment procedures of Part 7 of this Article.

(d) In addition to the notice of hearings and rehearings to the incompetent adult and his or her counsel required under Part 7 of this Article, notice shall be given by the clerk to the legally responsible ~~person,~~person or ~~his successor.~~a successor to the legally responsible person. The legally responsible ~~person,~~person or ~~his~~ a successor to the legally responsible person may also file with the clerk of court a written waiver of ~~his~~ the right to receive notice."

SECTION 19. G.S. 122C-251 reads as rewritten:

"**§ 122C-251. ~~Transportation.~~Custody and transportation.**

(a) Except as provided in subsections (f) and (g), transportation of a respondent within a county under the involuntary commitment proceedings of this Article, including admission and discharge, shall be provided by the city or county. The city has the duty to provide transportation of a respondent who is a resident of the city or who ~~is~~ can be taken into custody in the city limits. The county has the duty to provide transportation for a respondent who resides in the county outside city limits or who ~~is~~ can be taken into custody outside of city limits. However, cities and counties may contract with each other to provide transportation.

(b) Except as provided in subsections (f) and (g) or in G.S. 122C-408(b), transportation between counties under the involuntary commitment proceedings of this Article for admission to a 24-hour facility shall be provided by the county where the respondent is taken into custody. Transportation between counties under the involuntary commitment proceedings of this Article for respondents held in 24-hour facilities who have requested a change of venue for the district court hearing shall be provided by the county where the petition for involuntary commitment was initiated. Transportation between counties under the involuntary commitment proceedings of this Article for discharge of a respondent from a 24-hour facility shall be provided by the county of residence of the respondent. However, a respondent being discharged from a facility may use his own transportation at his own expense. Transportation between counties under the involuntary commitment proceedings of this Article for a first examination at a location described in G.S. 122C-263(a) and G.S. 122C-238(a) shall be provided by the county where the respondent is taken into custody.

(c) Transportation of a respondent may be (i) by city- or county-owned ~~vehicles or~~vehicles, (ii) by private vehicle by contract with the city or ~~county.~~county, or (iii) as provided in a plan adopted under subsection (g) of this section. To the extent feasible, law enforcement officers transporting respondents shall dress in plain clothes and shall travel in unmarked vehicles. Further, law enforcement officers, to the extent ~~possible,~~feasible, shall advise respondents when taking them into custody that they are not under arrest and have not committed a crime, but are being taken into custody and transported to receive treatment and for their own safety and that of others.

(d) To the extent feasible, in providing transportation of a respondent, a city or county shall provide a driver or attendant who is the same sex as the respondent, unless the ~~law enforcement~~ law enforcement officer allows a family member of the respondent to accompany the respondent in lieu of an attendant of the same sex as the respondent.

(e) In taking custody and providing transportation as required by this section, the ~~law enforcement~~law enforcement officer may not use ~~reasonable~~ force to restrain the respondent ~~if~~ unless it appears necessary to protect ~~himself,~~the law enforcement officer, the respondent, or others. The law enforcement officer shall use the least restrictive and most reasonable restraint under the circumstances and afford the respondent as much dignity as the circumstances permit, taking into consideration the age, medical condition, special needs, and

behavior of the respondent. To the extent feasible, the law enforcement officer's application of force or restraint shall avoid aggravating or worsening the respondent's preexisting injuries or medical conditions. To the extent feasible, the law enforcement officer shall consult a parent, caretaker, or other legally responsible person prior to restraining a minor. The law enforcement officer shall record on the return of service portion of the custody order the type of mechanical restraint used on a respondent, if any, when taking the respondent into custody or transporting the respondent. No ~~law enforcement~~law enforcement officer may be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes on account of reasonable measures taken under the authority of this Article. The limitations and conditions in this subsection on the use of force and restraint do not apply to acute care hospitals or general hospitals and their employees or contractors when the use of force and restraint by these entities and persons is governed by rules for accreditation adopted by accrediting bodies that review these entities and persons for compliance with the accreditation rules.

(f) Notwithstanding the provisions of subsections (a), (b), and (c) of this section, a clerk, a magistrate, or a district court judge, where applicable, may authorize the family or immediate friends of the respondent, if they so request, to transport the respondent in accordance with the procedures of this Article. This authorization shall only be granted in cases where the danger to the public, the family or friends of the respondent, or the respondent himself or herself is not substantial. The family or immediate friends of the respondent shall bear the costs of providing this transportation.

(g) The governing body of a ~~city or county~~ city, county, or LME/MCO may adopt a plan for the custody and transportation of respondents in involuntary commitment proceedings ~~in~~ under this Article. ~~Law enforcement personnel,~~ The plan may designate law enforcement officers, volunteers, or other public or private agency personnel ~~may be designated~~ to provide all or parts of the custody and transportation required by involuntary commitment ~~proceedings.~~proceedings, including taking a respondent into custody as ordered by a clerk of superior court or magistrate. Persons so designated shall be trained in accordance with G.S. 122C-202.2(a)(3) and the plan shall assure adequate safety and protections for both the public and the respondent. ~~Law enforcement,~~ Affected law enforcement agencies, acute care hospitals, magistrates, clerks of superior court, area facilities, other affected agencies, and the area authority shall participate in the planning. ~~If any person other than a law enforcement agency is designated by a city or county, the person so designated~~ Any person or agency designated by a city, county, or LME/MCO to provide all or parts of the custody and transportation required by involuntary commitment proceedings shall provide the custody and transportation and follow the procedures in this Article. References in this Article to a ~~law enforcement~~ law enforcement officer apply to this ~~person.~~designated person or agency. A person shall not be designated without the consent of (i) the person or (ii) the agency that employs the person or contracts for the person's services. Counties and cities shall retain the responsibilities set forth in this Article, except as otherwise described in a plan developed and adopted pursuant this subsection.

(h) The cost and expenses for custody and transportation of ~~transporting~~ a respondent ~~to or from a 24-hour facility~~as required by the involuntary commitment procedures of this Article is the responsibility of the county of residence of the ~~respondent.~~respondent unless otherwise provided in a plan adopted under subsection (g) of this section. The State (when providing transportation under G.S. 122C-408(b)), a city, or a county is entitled to recover the reasonable cost of transportation from the county of residence of the respondent. The county of residence of the respondent shall reimburse the State, another county, or a city the reasonable transportation costs incurred as authorized by this subsection. The county of residence of the respondent is entitled to recover the reasonable cost of transportation it has paid to the State, a city, or a county. Provided that the county of residence provides the respondent or other

individual liable for the respondent's support a reasonable notice and opportunity to object to the reimbursement, the county of residence of the respondent may recover that cost from:

(1) The respondent, if the respondent is not indigent;
(2) Any person or entity that is legally liable for the resident's support and maintenance provided there is sufficient property to pay the cost;
(3) Any person or entity that is contractually responsible for the cost; or
(4) Any person or entity that otherwise is liable under federal, State, or local law for the cost."

SECTION 20. G.S. 122C-253 reads as rewritten:

"**§ 122C-253. Fees under commitment order.**

Nothing contained in Parts 6, 7, or 8 of this Article requires a private physician, private psychologist, commitment examiner, or private facility to accept a respondent as a client either before or after commitment. Treatment at a private facility or by a private ~~physician or~~physician, private ~~psychologist~~ psychologist, or commitment examiner is at the expense of the respondent to the extent that the charges are not disposed of by contract between the area authority and the private facility. An area authority and its contract agencies shall set and recover fees for inpatient or outpatient treatment services provided under a commitment order in accordance with G.S. 122C-146."

SECTION 21. G.S. 122C-255 reads as rewritten:

"**§ 122C-255. Report required.**

~~Beginning January 1, 2012, each~~Each 24-hour ~~residential~~ facility that (i) falls under the category of nonhospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C .0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

(1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.
(2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.
(3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision."

SECTION 22. G.S. 122C-261 reads as rewritten:

"**§ 122C-261. Affidavit and petition before clerk or magistrate when immediate hospitalization is not necessary; custody order.**

(a) Anyone who has knowledge of an individual who is mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a clerk or assistant or deputy clerk of superior court or a magistrate and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. If the affiant has knowledge or reasonably believes that the respondent, in addition to being mentally ill, is also mentally retarded, this fact shall be stated in the affidavit. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, the clerk or magistrate shall issue an order to a law enforcement officer or any other person authorized under G.S. 122C-251 to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~commitment examiner. If the clerk or magistrate finds that, in addition to probably being mentally ill, the respondent is also probably mentally retarded, the clerk or magistrate shall contact the area authority before issuing a custody order and the area authority shall designate the facility to which the respondent is to be taken for examination by a ~~physician or eligible psychologist.~~commitment examiner. The clerk or magistrate shall provide the petitioner and the respondent, if present, with specific information regarding the next steps that will occur for the respondent.

(c) If the clerk or magistrate issues a custody order, the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) If the affiant is a ~~physician or eligible psychologist,~~commitment examiner, all of the following apply:

(1) ~~The~~ If the affiant has examined the respondent, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original ~~affidavit or~~ affidavit, by transmitting a copy in paper form that is printed through the facsimile transmission of the ~~affidavit.~~affidavit, or by delivering the affidavit through electronic transmission. If the affidavit is filed through electronic or facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit.

(2) This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). The affiant shall document in writing and file the examination findings with the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section.

(3) If the ~~physician or eligible psychologist~~commitment examiner recommends outpatient commitment according to the criteria for outpatient commitment set forth in G.S. 122C-263(d)(1) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. ~~The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician or eligible psychologist~~The commitment examiner shall contact the ~~local management entity~~LME/MCO that serves the county where the respondent resides or the ~~local management entity~~LME/MCO that coordinated services for the respondent to inform the ~~local management entity~~LME/MCO that the respondent is being recommended for outpatient commitment. The LME/MCO shall determine whether the respondent is a client of the LME/MCO or eligible for services through the LME/MCO and, if so, shall identify and schedule an

appointment with a proposed outpatient treatment physician or center and provide the commitment examiner with the name, address, and telephone number of the proposed outpatient treatment physician or center and the date and time that the respondent has been scheduled for an appointment with ~~an~~ the outpatient treatment physician or center. The commitment examiner shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center.

(4) If the ~~physician or eligible psychologist~~commitment examiner recommends inpatient commitment based on the criteria for inpatient commitment set forth in G.S. 122C-263(d)(2) and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order to a law enforcement officer or any other person authorized under G.S. 122C-251(g) to take the respondent into custody for transportation to ~~or custody at~~ a 24-hour facility described in ~~G.S. 122C-252, provided~~G.S. 122C-252; provided, however, that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2).

(5) If the affiant is a physician or eligible psychologist at a 24-hour facility described in G.S. 122C-252 who recommends inpatient commitment; the respondent is physically present on the premises of the same 24-hour facility; and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, then the clerk or magistrate may issue an order by facsimile transmission or may issue an electronically scanned order by electronic transmission to the physician or eligible psychologist at the 24-hour facility, or a designee, to take the respondent into custody at the 24-hour facility and proceed according to G.S. 122C-266. Upon receipt of the custody order, the physician or eligible psychologist at the 24-hour facility, or a designee, shall immediately (i) notify the respondent that the respondent is not under arrest and has not committed a crime but is being taken into custody to receive treatment and for the respondent's own safety and the safety of others, (ii) take the respondent into custody, and (iii) complete and sign the appropriate portion of the custody order and return the order to the clerk or magistrate either by facsimile transmission or by scanning it and sending it by electronic transmission. The physician or eligible psychologist, or a designee, shall mail the original custody order no later than five days after returning it by means of facsimile or electronic transmission to the clerk or magistrate. The clerk or magistrate shall file the original custody order with the copy of the custody order that was electronically returned.

Notwithstanding the provisions of this subdivision, a clerk or magistrate shall not issue a custody order to a physician or eligible psychologist at a 24-hour facility, or a designee, if the physician or eligible psychologist, or a designee, has not completed training in proper service and return of service. As used in this subdivision, the term "designee" includes the 24-hour facility's on-site police security personnel.

The Department of Health and Human Services shall cooperate and collaborate with the Administrative Office of the Courts and the UNC School of Government to develop protocols to implement this section,

including a procedure for notifying clerks and magistrates of the names of the physicians, psychologists, and designees who have completed the training. The Secretary of the Department shall oversee implementation of these protocols.

(6) If the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported.

(7) If a ~~physician or eligible psychologist~~commitment examiner executes an affidavit for inpatient commitment of a respondent, a ~~second~~ physician who is not the commitment examiner who performed the examination under this section shall be required to perform the examination required by G.S. 122C-266.

(8) No commitment examiner, area facility, acute care hospital, general hospital, or other site of first examination, or its officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment and who follows accepted professional judgment, standards, and practice, shall be held liable in any civil or criminal action for taking reasonable measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by subsection (d) of this section, as long as the commitment examiner has a reasonable and good-faith belief that detention pending the examination and issuance of a custody order is necessary to protect the individual or others from bodily harm or life endangerment. If the individual is temporarily detained under the circumstances described in this subdivision, the examiner shall certify in the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section the reason the individual requires temporary detention pending the issuance of a custody order.

(e) Except as provided in subdivision (5) of subsection (d) of this section, upon receipt of the custody order of the clerk or magistrate or a custody order issued by the court pursuant to G.S. 15A-1003, a law enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed, and proceed according to G.S. 122C-263. The custody order is valid throughout the State.

~~(f) When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a physician or eligible psychologist as set forth in G.S. 122C-263 shall be carried out in accordance with the area plan. Prior to issuance of a custody order for a respondent who resides in an area authority with a single portal plan, the clerk or magistrate shall communicate with the area authority to determine the appropriate 24-hour facility to which the respondent should be admitted according to the area plan or to determine if there are more appropriate resources available through the area authority to assist the petitioner or the respondent. When an individual from a single portal area is presented for commitment at a 24-hour area or State facility directly, the individual may not be accepted for admission until the facility notifies the area authority and the area authority agrees to the admission. If the area authority does not agree to the admission, it shall determine the appropriate 24-hour facility to which the individual should be admitted according to the area plan or determine if there are more appropriate resources available through the area authority to assist the individual. If the area authority agrees to the admission, further planning of treatment~~

~~for the client is the joint responsibility of the area authority and the facility as prescribed in the area plan.~~

Notwithstanding the provisions of this section, in no event shall an individual known or reasonably believed to be mentally retarded be admitted to a State psychiatric hospital, except as follows:

(1) Persons described in G.S. 122C-266(b);
(2) Persons admitted pursuant to G.S. 15A-1321;
(3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
(4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed."

SECTION 23. G.S. 122C-262 reads as rewritten:

"**§ 122C-262. Special emergency procedure for individuals needing immediate hospitalization.**

(a) Anyone, including a law enforcement officer, who has knowledge of an individual who is subject to inpatient commitment according to the criteria of ~~G.S. 122C-261(a)~~G.S. 122C-263(d)(2) and who requires immediate hospitalization to prevent harm to self or others, may transport the individual directly to an area facility or other place, including a State facility for the mentally ill, for examination by a ~~physician or eligible psychologist~~commitment examiner in accordance with G.S. 122C-263(c).

(b) Upon examination by the ~~physician or eligible psychologist,~~commitment examiner, if the individual meets the inpatient commitment criteria ~~required~~ specified in ~~G.S. 122C-261(a), the physician or eligible psychologist~~ G.S. 122C-263(d)(2) and requires immediate hospitalization to prevent harm to self or others, the commitment examiner shall so certify in writing before any official authorized to administer oaths. The certificate shall also state the reason that the individual requires immediate hospitalization. If the ~~physician or eligible psychologist~~commitment examiner knows or has reason to believe that the individual is mentally retarded, the certificate shall so state.

(c) If the ~~physician or eligible psychologist~~commitment examiner executes the oath, appearance before a magistrate shall be waived. The ~~physician or eligible psychologist~~commitment examiner shall send a copy of the certificate to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours, excluding Saturday, Sunday, and holidays, of the time that it was signed, the ~~physician or eligible psychologist~~commitment examiner shall also communicate the findings to the clerk by telephone.

(d) Anyone, including a law enforcement officer if necessary, may transport the individual to a 24-hour facility described in G.S. 122C-252 for examination and treatment pending a district court hearing. If there is no area 24-hour facility and if the respondent is

indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person providing transportation shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a and immediately notify the clerk of superior court of this action. The ~~physician's or eligible psychologist's~~commitment examiner's certificate shall serve as the custody order and the law enforcement officer or other designated person shall provide transportation in accordance with the provisions of G.S. 122C-251. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with G.S. 122C-263(d)(2).

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

(1) Persons described in G.S. 122C-266(b);
(2) Persons admitted pursuant to G.S. 15A-1321;
(3) Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
(4) Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(e) Respondents received at a 24-hour facility under the provisions of this section shall be examined by a second physician in accordance with G.S. 122C-266. After receipt of notification that the district court has determined reasonable grounds for the commitment, further proceedings shall be carried out in the same way as for all other respondents under this Part.

(f) If, upon examination of a respondent presented in accordance with subsection (a) of this section, the commitment examiner finds that the individual meets the criteria for inpatient commitment specified in G.S. 122C-263(d)(2) but does not require immediate hospitalization to prevent harm to self or others, the commitment examiner may petition the clerk or magistrate in accordance with G.S. 122C-261(d) for an order to take the individual into custody for transport to a 24-hour facility described in G.S. 122C-252. If the commitment examiner recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transport to or custody at a 24-hour facility described in G.S. 122C-252; provided, however, that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision in accordance with G.S. 122C-263(d)(2) and released in accordance with G.S. 122C-263(d)(2).

(g) This section applies exclusively to an individual who is transported to an examination by a commitment examiner in accordance with subsection (a) of this section."

SECTION 24. G.S. 122C-263 reads as rewritten:

"**§ 122C-263. Duties of ~~law enforcement~~law enforcement officer; first ~~examination by physician or eligible psychologist.~~examination.**

(a) Without unnecessary delay after assuming custody, the law enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2 for examination by a ~~physician or eligible psychologist; if a physician or eligible psychologist~~ commitment examiner. If an area facility identified in the plan or one of its commitment examiners is not ~~available in the area facility,~~available, or if there is no area facility identified in the plan, the person designated to provide transportation shall take the respondent to any ~~physician or eligible psychologist locally available. If a physician or eligible psychologist~~ acute care hospital identified by the LME/MCO in the community crisis services plan adopted pursuant to G.S. 122C-202.2. If a commitment examiner is not immediately ~~available,~~ available in such area facility or acute care hospital, the respondent may be temporarily detained ~~in an area facility, if one is available; if an area facility is not available, the respondent may be detained under appropriate supervision in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a State facility for the mentally ill,~~ under appropriate supervision in such area facility or acute care hospital but not in a jail or other penal facility. If no identified facility or acute care hospital is available, the law enforcement officer or other designated individual shall transport the respondent to any commitment examiner available in a private hospital or clinic, a general hospital, or a State facility for the mentally ill.

(a1) An area facility that is identified by the LME/MCO in accordance with G.S. 122C 202.2 as a site for conducting first examinations under subsection (a) of this section shall be capable of performing a medical screening examination of the respondent that consists of a history and physical appropriate to the respondent's complaint or condition, with ancillary testing as necessary. The medical screening examination shall be conducted by a physician or other individual who is determined by the area facility to be qualified to perform the medical screening and is practicing within the scope of his or her licensure. The respondent may either be in the physical face to face presence of the medical screening examiner or may be examined utilizing telemedicine equipment and procedures. If the area facility in subsection (a) of this section determines that an individual qualified to perform a medical screening examination appropriate to the respondent's complaint or condition is not available on-site or via telemedicine, the area facility shall identify and contact another area facility that is capable of performing the medical screening, or an acute care hospital, and the law enforcement officer or other designated person shall transport the respondent to the identified facility or hospital.

(a2) The responsible professional at an area facility or other site of first examination may transfer a respondent to an acute care hospital for emergency medical treatment, emergency medical evaluation, emergency surgery, or other medical treatment that the site of first examination is unable to provide by directing the law enforcement officer or other person designated under G.S. 122C 251(g) to transport the respondent to an identified acute care hospital. When the respondent is transferred solely for medical reasons, the original facility shall accept the return of the respondent and the respondent shall be returned to the original facility after the medical care is completed unless the responsible professionals at both facilities concur that the respondent no longer meets the criteria for commitment and recommend that the commitment proceedings be terminated. Any decision to terminate the proceedings shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section.

(b) The examination set forth in subsection (a) of this section is not required ~~if:~~under any of the following circumstances:

(1) The affiant who obtained the custody order is a ~~physician or eligible psychologist~~ commitment examiner who recommends inpatient ~~commitment;~~commitment.

(2) The custody order states that the respondent was charged with a violent crime, including a crime involving assault with a deadly weapon, and ~~he~~ the respondent was found incapable of ~~proceeding; or~~proceeding.

(3) Repealed by Session Laws 1987, c. 596, s. 3.

In any of these cases, the ~~law enforcement~~law enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

(c) The ~~physician or eligible psychologist~~commitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 ~~hours,~~hours after the respondent is presented for examination. When the examination set forth in subsection (a) of this section is performed by a ~~physician or eligible psychologist~~commitment examiner, the respondent may either be in the physical face-to-face presence of the ~~physician or eligible psychologist~~commitment examiner or may be examined utilizing telemedicine equipment and procedures. A ~~physician or eligible psychologist~~commitment examiner who examines a respondent by means of telemedicine must be satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (d) of this section would not be different if the examination had been done in the physical presence of the ~~physician or eligible psychologist. A physician or eligible psychologist~~commitment examiner. A commitment examiner who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under this section. As used in this ~~subsection,~~section, "telemedicine" is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

The examination shall include ~~but is not limited to~~ an assessment of ~~the respondent's:~~at least all of the following with respect to the respondent:

(1) Current and previous mental illness and mental retardation including, if available, previous treatment ~~history;~~history.

(2) Dangerousness to self, as defined in G.S. 122C-3(11)a. or others, as defined in ~~G.S. 122C-3(11)b.;~~G.S. 122C-3(11)b.

(3) Ability to survive safely without inpatient commitment, including the availability of supervision from family, friends or ~~others; and~~others.

(4) Capacity to make an informed decision concerning treatment.

(d) After the conclusion of the examination the ~~physician or eligible psychologist~~commitment examiner shall make the following determinations:

(1) If the ~~physician or eligible psychologist~~commitment examiner finds ~~that:~~all of the following:

a. The respondent is mentally ~~ill;~~ill.

b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or ~~others;~~others.

c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by ~~G.S. 122C-3(11); and~~G.S. 122C-3(11).

d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The ~~physician or eligible psychologist~~commitment examiner shall so show on the examination report and shall recommend outpatient commitment. In addition the examining ~~physician or eligible psychologist~~commitment examiner shall show the name, address, and telephone number of the proposed outpatient treatment physician or ~~center.~~center in accordance with subsection (f) of this section. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

(2) If the ~~physician or eligible psychologist~~commitment examiner finds that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the ~~physician or eligible psychologist~~commitment examiner shall recommend inpatient commitment, and shall so show on the examination report. If, in addition to mental illness and dangerousness, the ~~physician or eligible psychologist~~commitment examiner also finds that the respondent is known or reasonably believed to be mentally retarded, this finding shall be shown on the report. ~~The~~ Without unnecessary delay, and in any event within six hours after the comment examiner's finding and recommendation, the law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action. If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision at the site of the first ~~examination, provided that at anytime that a physician or eligible psychologist~~examination. Upon the commitment examiner's determination that a 24-hour facility is available and medically appropriate, the law enforcement officer or other designated person shall commence transporting the respondent without unnecessary delay and, in any event, within six hours after receiving a request for transportation by the commitment examiner. At any time during the respondent's temporary detention under appropriate supervision, if a commitment examiner determines that the respondent is no longer in need of inpatient commitment, the proceedings shall be terminated and the respondent transported and released in accordance with subdivision (3) of this subsection. However, if the ~~physician or eligible psychologist~~commitment examiner determines that the respondent meets the criteria for outpatient commitment, as defined in subdivision (1) of this subsection, the ~~physician or eligible psychologist~~commitment examiner may recommend outpatient commitment, and the respondent shall be transported and released in accordance with subdivision (1) of this subsection. Any

decision to terminate the proceedings or to recommend outpatient commitment after an initial recommendation of inpatient commitment shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section. If the respondent is temporarily detained and a 24-hour facility is not available or medically appropriate seven days after the issuance of the custody order, a ~~physician or psychologist~~commitment examiner shall report this fact to the clerk of superior court and the proceedings shall be terminated. Termination of proceedings pursuant to this subdivision shall not prohibit or prevent the initiation of new involuntary commitment proceedings when appropriate. A commitment examiner may initiate a new involuntary commitment proceeding prior to the expiration of this seven-day period, as long as the respondent continues to meet applicable criteria. Affidavits filed in support of proceedings terminated pursuant to this subdivision may not be submitted in support of any subsequent petitions for involuntary commitment. If the affiant initiating new commitment proceedings is a ~~physician or eligible psychologist~~commitment examiner, the affiant shall conduct a new examination and may not rely upon examinations conducted as part of proceedings terminated pursuant to this subdivision.

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

a. Persons described in G.S. 122C-266(b);
b. Persons admitted pursuant to G.S. 15A-1321;
c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(3) If the ~~physician or eligible psychologist~~commitment examiner finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody.

(e) The findings of the ~~physician or eligible psychologist~~commitment examiner and the facts on which they are based shall be in writing in all cases. The ~~physician or eligible~~

~~psychologist~~commitment examiner shall send a copy of the findings to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours of the time that it was signed, the ~~physician or eligible psychologist~~commitment examiner shall also communicate his findings to the clerk by telephone.

(f) When outpatient commitment is recommended, the ~~examining physician or eligible psychologist,~~commitment examiner, if different from the proposed outpatient treatment physician or center, ~~shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time. The examining physician or eligible psychologist before the appointment shall notify by telephone the designated outpatient treatment physician or center and shall send a copy of the notice and his examination report to the physician or center.~~shall contact the LME/MCO that serves the county where the respondent resides or the LME/MCO that coordinated services for the respondent to inform the LME/MCO that the respondent is being recommended for outpatient commitment. The LME/MCO shall determine whether the respondent is a client of the LME/MCO or eligible for services through the LME/MCO and, if so, shall identify and schedule an appointment with a proposed outpatient treatment physician or center and provide the commitment examiner with the name, address, and telephone number of the proposed outpatient treatment physician or center and the date and time the respondent has been scheduled for an appointment with the outpatient treatment physician or center. The commitment examiner shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time. Prior to the appointment, the commitment examiner shall notify by telephone the designated outpatient treatment physician or center and shall send a copy of the notice and the commitment examiner's examination report to the physician or center.

(g) The ~~physician or eligible psychologist,~~ commitment examiner, at the completion of the examination, shall provide the respondent with specific information regarding the next steps that will occur."

SECTION 25. G.S. 122C-263.1 reads as rewritten:

"**§ 122C-263.1. Secretary's authority to ~~waive requirement of first examination by physician or eligible psychologist;~~certify commitment examiners; training of certified ~~providers~~ commitment examiners performing first ~~examinations.~~examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services ~~may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:~~may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283, other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a ~~request from an LME to substitute for a physician or eligible psychologist,~~ request:

a. To certify a licensed clinical social worker, a master's level ~~psychiatric nurse, or~~ nurse practitioner, a licensed professional counselor, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level ~~certified~~ licensed clinical addictions specialist ~~in accordance with subdivision (8) of this subsection to conduct the initial (first level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:~~to conduct the first examination described in G.S. 122C-283(c).

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

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

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

(2) The Secretary shall review the request and may approve it upon finding all of the following:

a. The request meets the requirements of this section.

~~b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.~~

~~c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.~~

d. The Department determines that the applicant possesses the professional licensure, registration, or certification to qualify the applicant as a professional whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment.

e. The applicant for certification has successfully completed the Department's standardized training program for involuntary commitment and has successfully passed the examination for that program.

~~(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.~~

(4) A ~~waiver~~ certification granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the ~~LME~~ certified individual has failed to meet the requirements of this section. Certification may be renewed every three years upon completion of a refresher training program approved by the Department.

(5) In no event shall the ~~substitution~~ certification of a licensed clinical social worker, master's level ~~psychiatric nurse,~~nurse practitioner, licensed professional counselor, physician assistant, or master's level certified clinical addictions specialist ~~under a waiver granted~~ under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, ~~the~~ master's level ~~psychiatric nurse,~~nurse practitioner, licensed

professional counselor, physician assistant, or ~~the~~ master's level certified clinical addictions specialist.

(6) The Department shall require that individuals ~~performing~~ certified to perform initial examinations under ~~the waiver have~~this section have successfully completed the Department's standardized involuntary commitment training program and examination. The Department shall maintain a list of these individuals on its Internet Web site.

~~(7) As part of its waiver request, the LME shall document the availability of a physician to provide backup support.~~

(7a) No less than annually, the Department shall submit a list of certified first commitment examiners to the Chief District Court Judge of each judicial district in North Carolina and maintain a current list of certified first commitment examiners on its Internet Web site.

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

(b) The ~~Division of Mental Health, Developmental Disabilities, and Substance Abuse Services~~ Department shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 26. G.S. 122C-264 reads as rewritten:

"**§ 122C-264. Duties of clerk of superior court and the district attorney.**

(a) Upon receipt of a ~~physician's or eligible psychologist's~~commitment examiner's finding that the respondent meets the criteria of G.S. 122C-263(d)(1) and that outpatient commitment is recommended, the clerk of superior court of the county where the petition was initiated, upon direction of a district court judge, shall calendar the matter for hearing and shall notify the respondent, the proposed outpatient treatment physician or center, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.

(b) Upon receipt by the clerk of superior court pursuant to G.S. 122C-266(c) of a physician's ~~or eligible psychologist's~~ finding that a respondent meets the criteria of G.S. 122C-263(d)(2) and that inpatient commitment is recommended, the clerk of superior court of the county where the 24-hour facility is located shall, after determination required by G.S. 122C-261(c) and upon direction of a district court judge, assign counsel if necessary, calendar the matter for hearing, and notify the respondent, his counsel, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of his right to notice under this subsection with the clerk of court.

(b1) Upon receipt of a ~~physician's or eligible psychologist's~~commitment examiner's certificate that a respondent meets the criteria of G.S. 122C-261(a) and that immediate hospitalization is needed pursuant to G.S. 122C-262, the clerk of superior court of the county where the treatment facility is located shall submit the certificate to the Chief District Court Judge. The court shall review the certificate within 24 hours, excluding Saturday, Sunday, and holidays, for a finding of reasonable grounds in accordance with 122C-261(b). The clerk shall notify the treatment facility of the court's findings by telephone and shall proceed as set forth in subsections (b), (c), and (f) of this section.

…."

SECTION 27. G.S. 122C-265 reads as rewritten:

"**§ 122C-265. Outpatient commitment; examination and treatment pending hearing.**

(a) If a respondent, who has been recommended for outpatient commitment by ~~an examining physician or eligible psychologist~~ a commitment examiner different from the proposed outpatient treatment physician or center, fails to appear for examination by the

proposed outpatient treatment physician or center at the designated time, the physician or center shall notify the clerk of superior court who shall issue an order to a law-enforcement officer or other person authorized under G.S. 122C-251 to take the respondent into custody and take him immediately to the outpatient treatment physician or center for evaluation. The custody order is valid throughout the State. The law-enforcement officer may wait during the examination and return the respondent to his home after the examination.

(b) The ~~examining physician~~ commitment examiner or the proposed outpatient treatment physician or center may prescribe to the respondent reasonable and appropriate medication and treatment that are consistent with accepted medical standards pending the district court hearing.

(c) In no event may a respondent released on a recommendation that he or she meets the outpatient commitment criteria be physically forced to take medication or forceably detained for treatment pending a district court hearing.

(d) If at any time pending the district court hearing the outpatient treatment physician or center determines that the respondent does not meet the criteria of G.S. 122C-263(d)(1), ~~he~~ the physician shall release the respondent and notify the clerk of court and the proceedings shall be terminated.

(e) If a respondent becomes dangerous to ~~himself,~~ self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., pending a district court hearing on outpatient commitment, new proceedings for involuntary inpatient commitment may be initiated.

(f) If an inpatient commitment proceeding is initiated pending the hearing for outpatient commitment and the respondent is admitted to a 24-hour facility to be held for an inpatient commitment hearing, notice shall be sent by the clerk of court in the county where the respondent is being held to the clerk of court of the county where the outpatient commitment was initiated and the outpatient commitment proceeding shall be terminated."

SECTION 28. G.S. 122C-266(a)(2) reads as rewritten:

"(2) If the physician finds that the respondent meets the criteria for outpatient commitment under G.S. 122C-263(d)(1), the physician shall show these findings on the physician's examination report, release the respondent pending the district court hearing, and notify the clerk of superior court of the county where the petition was initiated of these findings. In addition, the examining physician shall show on the examination report the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician shall contact the LME/MCO that serves the county in which the respondent resides or that coordinated services for the respondent to inform the LME/MCO that the respondent is being recommended for outpatient commitment. The LME/MCO shall determine whether the respondent is a client of the LME/MCO or eligible for services through the LME/MCO and, if so, shall identify and schedule an appointment with a proposed outpatient treatment physician or center and provide the commitment examiner with the name, address, and telephone number of the proposed outpatient treatment physician or center and the date and time that the respondent has been scheduled for an appointment with the outpatient treatment physician or center. The physician shall give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at that address at a specified date and time. The examining physician before the appointment shall notify by telephone and shall send a copy of the notice and the examination report to the proposed outpatient treatment physician or center."

SECTION 29. G.S. 122C-267(c) reads as rewritten:

"(c) Certified copies of reports and findings of ~~physicians and psychologists~~commitment examiners and medical records of previous and current treatment are admissible in evidence."

SECTION 30. G.S. 122C-268 reads as rewritten:

"**§ 122C-268. Inpatient commitment; district court hearing.**

(a) A hearing shall be held in district court within 10 days of the day the respondent is taken into law enforcement custody pursuant to G.S. 122C-261(e) or G.S. 122C-262. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day that the respondent is taken into custody under the most recent custody order. A continuance of not more than five days may be granted upon motion ~~of:~~of any of the following:

(1) The ~~court;~~court.

(2) Respondent's ~~counsel; or~~counsel.

(3) The State, sufficiently in advance to avoid movement of the respondent.

...

(f) Certified copies of reports and findings of ~~physicians and psychologists~~commitment examiners and previous and current medical records are admissible in evidence, but the respondent's right to confront and cross-examine witnesses may not be denied.

(g) ~~Hearings may~~ To the extent feasible, hearings shall be held in an appropriate room ~~not used for treatment of clients~~ at the facility in which the respondent is being treated ~~if it~~in a manner approved by the chief district court judge if the facility is located within the presiding judge's district court district as defined in ~~G.S. 7A-133, by interactive videoconferencing between a treatment facility and a courtroom, or~~G.S. 7A-133. Hearings may be held in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available. A hearing may be held by audio and video transmission between the treatment facility and a courtroom in a manner that allows (i) the judge and the respondent to see and hear each other and (ii) the respondent to communicate fully and confidentially with the respondent's counsel during the proceeding. Prior to any hearing held by audio and video transmission, the chief district court judge shall submit to the Administrative Office of the Courts the procedures and type of equipment for audio and video transmission for approval by the Administrative Office of the Courts. Notwithstanding the provisions of this subsection, if the respondent, through counsel, objects to a hearing held by audio and video transmission, the hearing shall be held in the physical presence of the presiding district court judge. Regardless of the manner and location for hearings, hearings shall be held in a manner that complies with any applicable federal and State laws governing the confidentiality and security of confidential information, including any information transmitted from the treatment facility by audio and video transmission.

...."

SECTION 31. G.S. 122C-271 reads as rewritten:

"**§ 122C-271. Disposition.**

(a) If ~~an examining physician or eligible psychologist~~a commitment examiner has recommended outpatient commitment and the respondent has been released pending the district court hearing, the court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill; that he is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined in G.S. 122C-3(11); and that the respondent's current mental status or the nature of his illness limits or negates his ability to make an informed decision to seek voluntarily or

comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days.

(2) If the court does not find that the respondent meets the criteria of commitment set out in subdivision (1) of this subsection, the respondent shall be discharged and the ~~facility at which he was last a client~~proposed outpatient physician or center so notified.

(3) Before ordering any outpatient commitment under this subsection, the court shall make findings of fact as to the availability of outpatient treatment from an outpatient treatment physician or center that has agreed to accept the respondent as a client of outpatient treatment services. The court shall show on the order the outpatient treatment physician or center that is to be responsible for the management and supervision of the respondent's outpatient commitment. If the designated outpatient treatment physician or center will be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the court shall show on the order the identity of the LME/MCO. The clerk of court shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or center and to the respondent client or the legally responsible person. If the designated outpatient treatment physician or center will be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the clerk of court shall also send a copy of the order to that LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician under this section, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, but in no event less than 48 hours after the hearing.

(b) If the respondent has been held in a 24-hour facility pending the district court hearing pursuant to G.S. 122C-268, the court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill; that the respondent is capable of surviving safely in the community with available supervision from family, friends, or others; that based on respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and that the respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision voluntarily to seek or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days. If the commitment proceedings were initiated as the result of the respondent's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found incapable of proceeding, the commitment order shall so show.

(2) If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., it may order inpatient commitment at a 24-hour facility described in G.S. 122C-252 for a period not in excess of 90 days. However, no respondent found to be both mentally retarded and mentally ill may be committed to a State, area or private facility for the mentally retarded. An individual who is mentally ill and dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., may also be committed to a combination of inpatient

and outpatient commitment at both a 24-hour facility and an outpatient treatment physician or center for a period not in excess of 90 days. If the commitment proceedings were initiated as the result of the respondent's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found incapable of proceeding, the commitment order shall so show. If the court orders inpatient commitment for a respondent who is under an outpatient commitment order, the outpatient commitment is terminated; and the clerk of the superior court of the county where the district court hearing is held shall send a notice of the inpatient commitment to the clerk of superior court where the outpatient commitment was being supervised.

(3) If the court does not find that the respondent meets either of the commitment criteria set out in subdivisions (1) and (2) of this subsection, the respondent shall be discharged, and the facility in which the respondent was last a client so notified.

(4) Before ordering any outpatient commitment, ~~the court shall make findings of fact as to the availability of outpatient treatment. The court shall also show on the order the outpatient treatment physician or center who is to be responsible for the management and supervision of the respondent's outpatient commitment. When an outpatient commitment order is issued for a respondent held in a 24-hour facility, the court may order the respondent held at the facility for no more than 72 hours in order for the facility to notify the designated outpatient treatment physician or center of the treatment needs of the respondent.~~including any combination of inpatient and outpatient commitment, the 24-hour facility shall identify for the court an outpatient treatment physician or center that meets all of the following criteria:

a. Has participated in discharge planning for the respondent.

b. Has agreed to accept the respondent as a client of outpatient treatment services.

c. Has scheduled the respondent for an outpatient appointment to take place no later than seven days after the respondent's discharge from the 24-hour facility.

The court shall make findings of fact as to the availability of an outpatient treatment physician or center that has met the conditions of this subsection. If the respondent is a client of an LME/MCO or eligible for services through an LME/MCO, and before the court orders any outpatient commitment, the LME/MCO shall participate in the respondent's discharge planning and assist the 24-hour facility in identifying an outpatient treatment physician or center that is able to comply with the provisions of this subsection. The court shall show on the order the outpatient treatment physician or center who is responsible for the management and supervision of the respondent's outpatient commitment. If the treatment center or physician shall be providing outpatient treatment services to the respondent pursuant to a contract for services with an LME/MCO, the order shall also show the LME/MCO. The clerk of court in the county where the facility is located shall send a copy of the outpatient commitment order to the designated outpatient treatment physician or ~~center.~~center and to the respondent or the legally responsible person. If the designated outpatient treatment physician or center shall be monitoring and supervising the respondent's outpatient commitment pursuant to a contract for services with an LME/MCO, the

clerk of court shall also send a copy of the order to the LME/MCO. Copies of outpatient commitment orders sent by the clerk of court to an outpatient treatment center or physician pursuant to this subdivision, including orders sent to an LME/MCO, shall be sent by the most reliable and expeditious means, but in no event less than 48 hours after the hearing. If the outpatient commitment will be supervised in a county other than the county where the commitment originated, the court shall order venue for further court proceedings to be transferred to the county where the outpatient commitment will be supervised. Upon an order changing venue, the clerk of superior court in the county where the commitment originated shall transfer the file to the clerk of superior court in the county where the outpatient commitment is to be supervised.

(c) If the respondent was found not guilty by reason of insanity and has been held in a 24-hour facility pending the court hearing held pursuant to G.S. 122C-268.1, the court may make one of the following dispositions:

(1) If the court finds that the respondent has not proved by a preponderance of the evidence that he no longer has a mental illness or that he is no longer dangerous to others, it shall order inpatient treatment at a 24-hour facility for a period not to exceed 90 days.

(2) If the court finds that the respondent has proven by a preponderance of the evidence that he no longer has a mental illness or that he is no longer dangerous to others, the court shall order the respondent discharged and released."

SECTION 32. G.S. 122C-276(c) reads as rewritten:

"(c) Subject to the provisions of G.S. 122C-269(c), rehearings shall be held ~~at the facility in which the respondent is receiving treatment.~~ as authorized in G.S. 122C-268(g). The judge is a judge of the district court of the district court district as defined in G.S. 7A-133 in which the facility is located or a district court judge temporarily assigned to that district."

SECTION 33. G.S. 122C-281 reads as rewritten:

"**§ 122C-281. Affidavit and petition before clerk or magistrate; custody order.**

(a) Any individual who has knowledge of a substance abuser who is dangerous to ~~himself~~ self or others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate, execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~commitment examiner. The affidavit shall include the facts on which the affiant's opinion is based. Jurisdiction under this subsection is in the clerk or magistrate in the county where the respondent resides or is found.

(b) If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably a substance abuser and dangerous to ~~himself~~ self or others, ~~he~~ the clerk or magistrate shall issue an order to a ~~law enforcement~~law enforcement officer or any other person authorized by G.S. 122C-251 to take the respondent into custody for examination by a ~~physician or eligible psychologist.~~commitment examiner.

(c) If the clerk or magistrate issues a custody order, ~~he~~ the clerk or magistrate shall also make inquiry in any reliable way as to whether the respondent is indigent within the meaning of G.S. 7A-450. A magistrate shall report the result of this inquiry to the clerk.

(d) If the affiant is a ~~physician or eligible psychologist,~~commitment examiner who has examined the respondent, he or she may execute the affidavit before any official authorized to administer oaths. ~~He~~ The commitment examiner is not required to appear before the clerk or magistrate for this purpose. ~~His~~ The commitment examiner's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-283(c). Such affiant shall file the affidavit and examination findings with the clerk of court in the manner described in

G.S. 122C-261(d)(1). If the ~~physician or eligible psychologist~~commitment examiner recommends commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for commitment, ~~he~~ the clerk or magistrate shall issue an order to a law enforcement officer or other person designated under G.S. 122C-251(g) to take the respondent into custody for transportation to ~~or custody at~~ a 24-hour ~~facility or release the respondent,~~facility; or if the respondent is released pending hearing, as described in ~~G.S. 122C-283(d)(1).~~G.S. 122C-283(d)(1), order that a hearing be held as provided in G.S. 122C-284(a). If a physician or eligible psychologist executes an affidavit for commitment of a respondent, a second qualified professional shall perform the examination required by G.S. 122C-285.

(e) Upon receipt of the custody order of the clerk or magistrate, a ~~law enforcement~~law enforcement officer or other person designated in the order shall take the respondent into custody within 24 hours after the order is signed. The custody order is valid throughout the State.

(e1) No commitment examiner, area facility, acute care hospital, general hospital, or other site of first examination, or their officials, staff, employees, or other individuals responsible for the custody, examination, detention, management, supervision, treatment, or release of an individual examined for commitment and who follows accepted professional judgment, standards, and practice, shall be held liable in any civil or criminal action for taking reasonable measures to temporarily detain an individual for the period of time necessary to complete a commitment examination, submit an affidavit to the magistrate or clerk of court, and await the issuance of a custody order as authorized by subsection (d) of this section, as long as the commitment examiner has a reasonable and good-faith belief that detention pending the examination and issuance of a custody order is necessary to protect the individual or others from bodily harm or life endangerment. If the individual is temporarily detained under the circumstances described in this subsection, the commitment examiner shall certify in the affidavit delivered to the clerk or magistrate in accordance with subdivision (d)(1) of this section the reason the individual requires temporary detention pending the issuance of a custody order.

~~(f) When a petition is filed for an individual who is a resident of a single portal area, the procedures for examination by a physician or eligible psychologist as set forth in G.S. 122C-283(c) shall be carried out in accordance with the area plan. When an individual from a single portal area is presented for commitment at a facility directly, he may be accepted for admission in accordance with G.S. 122C-285. The facility shall notify the area authority within 24 hours of admission and further planning of treatment for the individual is the joint responsibility of the area authority and the facility as prescribed in the area plan.~~"

SECTION 34. G.S. 122C-282 reads as rewritten:

"**§ 122C-282. Special emergency procedure for violent individuals.**

When an individual subject to commitment under the provisions of this Part is also violent and requires restraint and when delay in taking ~~him~~ the individual to a ~~physician or eligible psychologist~~commitment examiner for examination would likely endanger life or property, a ~~law enforcement~~law enforcement officer may take the person into custody and take him or her immediately before a magistrate or clerk. The ~~law enforcement~~law enforcement officer shall execute the affidavit required by G.S. 122C-281 and in addition shall swear that the respondent is violent and requires restraint and that delay in taking the respondent to a ~~physician or eligible psychologist~~commitment examiner for an examination would endanger life or property.

If the clerk or magistrate finds by clear, cogent, and convincing evidence that the facts stated in the affidavit are true, that the respondent is in fact violent and requires restraint, and that delay in taking the respondent to a ~~physician or eligible psychologist~~commitment examiner for an examination would endanger life or property, ~~he~~ the clerk or magistrate shall order the

~~law-enforcement~~law enforcement officer to take the respondent directly to a 24-hour facility described in G.S. 122C-252.

Respondents received at a 24-hour facility under the provisions of this section shall be examined and processed thereafter in the same way as all other respondents under this Part."

SECTION 35. G.S. 122C-283 reads as rewritten:

"**§ 122C-283. Duties of law-enforcement officer; first examination by ~~physician or eligible psychologist.~~commitment examiner.**

(a) Without unnecessary delay after assuming custody, the law-enforcement officer or the individual designated by the clerk or magistrate under G.S. 122C-251(g) to provide transportation shall take the respondent to an area facility identified by the LME/MCO in the crisis services plan adopted pursuant to G.S. 122C-202.2 for examination by a ~~physician or eligible psychologist; if a physician or eligible psychologist~~commitment examiner. If the area facility identified in the plan or one of the facility's commitment examiners is not ~~available in the area facility, he~~available, the person designated to provide transportation shall take the respondent to any ~~physician or eligible psychologist locally available. If a physician or eligible psychologist is not immediately available, the respondent may be temporarily detained in an area facility if one is available; if an area facility is not available, he may be detained under appropriate supervision, in his home,~~other area facility or an acute care hospital as identified and provided in the LME/MCO's community crisis services plan adopted pursuant to G.S. 122C-202.2. If no identified facility or hospital is available, the respondent shall be transported to any commitment examiner available in a private hospital or a clinic, or in a general ~~hospital,~~hospital. If a commitment examiner is not available in an area facility or acute care hospital, the respondent may be temporarily detained under appropriate supervision in the area facility or hospital but not in a jail or other penal facility.

(a1) An area facility that is identified by the LME/MCO in accordance with G.S. 122C-202.2 as a site for conducting first examinations under subsection (a) of this section shall be capable of performing a medical screening examination of the respondent that consists of a history and physical appropriate to the respondent's complaint or condition, with ancillary testing as necessary. The medical screening examination shall be conducted by a physician or other individual who is determined by the area facility to be qualified to perform the medical screening and is practicing within the scope of his or her licensure. The respondent may either be in the physical face-to-face presence of the medical screening examiner or may be examined utilizing telemedicine equipment and procedures. If the area facility in subsection (a) of this section determines that an individual qualified to perform a medical screening examination appropriate to the respondent's complaint or condition is not available on-site or via telemedicine, the area facility shall identify and contact another area facility that is capable of performing the medical screening, or an acute care hospital, and the law enforcement officer or other designated person shall transport the respondent to the identified facility or hospital.

(a2) The responsible professional at an area facility or other site of first examination may transfer a respondent to an acute care hospital for emergency medical treatment, emergency medical evaluation, emergency surgery, or other medical treatment that the site of first examination is unable to provide by directing the law enforcement officer or other person designated under G.S. 122C-251(g) to transport the respondent to an identified acute care hospital. When the respondent is transferred solely for medical reasons, the original facility shall accept the return of the respondent and the respondent shall be returned to the original facility after the medical care is completed unless the responsible professionals at both facilities concur that the respondent no longer meets the criteria for commitment and recommend that the commitment proceedings be terminated. Any decision to terminate the proceedings shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section.

(b) The examination set forth in subsection (a) of this section is not required ~~if:~~under either of the following circumstances:

(1) The affiant who obtained the custody order is a ~~physician or eligible psychologist; or~~commitment examiner.

(2) The respondent is in custody under the special emergency procedure described in G.S. 122C-282.

In these cases when it is recommended that the respondent be detained in a 24-hour facility, the law-enforcement officer shall take the respondent directly to a 24-hour facility described in G.S. 122C-252.

(c) The ~~physician or eligible psychologist~~commitment examiner described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. The examination shall include but is not limited to an assessment of the respondent's:

(1) Current and previous substance abuse including, if available, previous treatment history; and

(2) Dangerousness to himself or others as defined in G.S. 122C-3(11).

(d) After the conclusion of the ~~examination~~examination, the ~~physician or eligible psychologist~~commitment examiner shall make the following determinations:

(1) If the ~~physician or eligible psychologist~~commitment examiner finds that the respondent is a substance abuser and is dangerous to ~~himself~~ self or others, ~~he~~ the commitment examiner shall recommend commitment and whether the respondent should be released or be held at a 24-hour facility pending hearing and shall so show on [the] his examination report. Based on the ~~physician's or eligible psychologist's~~commitment examiner's ~~recommendation~~recommendation, the ~~law enforcement~~law enforcement officer or other designated individual shall take the respondent to a 24-hour facility described in G.S. 122C-252 or release the respondent. If a 24-hour facility is not immediately available or medically appropriate, the respondent may be temporarily detained under appropriate supervision and the procedures described in G.S. 122C-263(d)(2) shall apply.

(2) If the ~~physician or eligible psychologist~~commitment examiner finds that the condition described in subdivision (1) of this subsection does not exist, the respondent shall be released and the proceedings terminated.

(e) The findings of the ~~physician or eligible psychologist~~commitment examiner and the facts on which they are based shall be in writing in all cases. A copy of the findings shall be sent to the clerk of superior court by the most reliable and expeditious means. If it cannot be reasonably anticipated that the clerk will receive the copy within 48 hours ~~of~~ after the time ~~that~~ it was signed, the ~~physician or eligible psychologist~~commitment examiner shall also communicate ~~his~~ the findings to the clerk by telephone."

SECTION 36. G.S. 122C-284 reads as rewritten:

"**§ 122C-284. Duties of clerk of superior court.**

(a) Upon receipt by the clerk of superior court of a ~~physician's or eligible psychologist's~~ finding made by a commitment examiner or other qualified professional pursuant to G.S. 122C-285(c) that a respondent is a substance abuser and dangerous to ~~himself~~ self or others and that commitment is recommended, the clerk of superior court of the county where the facility is located, if the respondent is held in a 24-hour facility, or the clerk of superior court where the petition was initiated shall upon direction of a district court judge assign counsel, calendar the matter for hearing, and notify the respondent, ~~his~~ respondent's counsel, and the petitioner of the time and place of the hearing. The petitioner may file a written waiver of ~~his~~ the right to notice under this subsection with the clerk of court.

(b) Notice to the respondent required by subsection (a) of this section shall be given as provided in G.S. 1A-1, Rule 4(j) at least 72 hours before the hearing. Notice to other individuals shall be given by mailing at least 72 hours before the hearing a copy by first-class mail postage prepaid to the individual at his or her last known address. G.S. 1A-1, Rule 6 shall not apply.

(c) Upon receipt of notice that transportation is necessary to take a committed respondent to a 24-hour facility pursuant to G.S. 122C-290(b), the clerk shall issue a custody order for the respondent.

(d) The clerk of superior court shall upon the direction of a district court judge calendar all hearings, supplemental hearings, and rehearings and provide all notices required by this Part."

SECTION 37. G.S. 122C-285 reads as rewritten:

"**§ 122C-285. Commitment; second examination and treatment pending hearing.**

(a) Within 24 hours of arrival at a 24-hour facility described in G.S. 122C-252, the respondent shall be examined by a qualified professional. This professional shall be a physician if the initial commitment evaluation was conducted by ~~an eligible psychologist.~~a commitment examiner who is not a physician. The examination shall include the assessment specified in G.S. 122C-283(c). If the physician or qualified professional finds that the respondent is a substance abuser and is dangerous to ~~himself~~ self or others, ~~he~~ the physician or qualified professional shall hold and treat the respondent at the facility or designate other treatment pending the district court hearing. If the physician or qualified professional finds that the respondent does not meet the criteria for commitment under G.S. 122C-283(d)(1), ~~he~~ the physician or qualified professional shall release the respondent and the proceeding shall be terminated. In this case the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the custody order originated. If the respondent is released, the ~~law enforcement~~ law enforcement officer or other person designated to provide transportation shall return the respondent to the originating county.

(b) If the 24-hour facility described in G.S. 122C-252 is the facility in which the first examination by a ~~physician or eligible psychologist~~commitment examiner occurred and is the same facility in which the respondent is held, the second examination must occur not later than the following regular working day.

(c) The findings of the physician or qualified professional along with the facts on which they are based shall be made in writing in all cases. A copy of the written findings shall be sent to the clerk of superior court by reliable and expeditious means."

SECTION 38. G.S. 122C-286 reads as rewritten:

"**§ 122C-286. Commitment; district court hearing.**

(a) A hearing shall be held in district court within 10 days of the day the respondent is taken into custody. If a respondent temporarily detained under G.S. 122C-263(d)(2) is subject to a series of successive custody orders issued pursuant to G.S. 122C-263(d)(2), the hearing shall be held within 10 days after the day the respondent is taken into custody under the most recent custody order. Upon its own motion or upon motion of the responsible professional, the respondent, or the State, the court may grant a continuance of not more than five days.

(b) The respondent shall be present at the ~~hearing.~~hearing unless the respondent, through counsel, submits a written waiver of personal appearance. A subpoena may be issued to compel the respondent's presence at a hearing. The petitioner and the responsible professional of the area ~~authority~~ facility or the proposed treating physician or ~~his~~ a designee of the proposed treating physician may be present and may provide testimony.

(c) Certified copies of reports and findings of ~~physicians and psychologists~~physicians, psychologists, and other commitment examiners and medical records of previous and current treatment are admissible in evidence, but the respondent's right to confront and cross-examine witnesses shall not be denied.

(d) The respondent may be represented by counsel of ~~his~~ choice. If the respondent is indigent within the meaning of G.S. 7A-450, counsel shall be appointed to represent the respondent in accordance with rules adopted by the Office of Indigent Defense Services.

(e) Hearings may be held at a facility if it is located within the judge's district court district as defined in G.S. 7A-133 or in the judge's chambers. A hearing may not be held in a regular courtroom, over objection of the respondent, if in the discretion of a judge a more suitable place is available.

(f) The hearing shall be closed to the public unless the respondent requests otherwise. The hearing for a respondent being held at a 24-four facility shall be held in a location and in the manner provided in G.S. 122C-268(g).

(g) A copy of all documents admitted into evidence and a transcript of the proceedings shall be furnished to the respondent on request by the clerk upon the direction of a district court judge. If the respondent is indigent, the copies shall be provided at State expense.

(h) To support a commitment order, the court shall find by clear, cogent, and convincing evidence that the respondent meets the criteria specified in G.S. 122C-283(d)(1). The court shall record the facts that support its findings and shall show on the order the area ~~authority~~ facility or physician who is responsible for the management and supervision of the respondent's treatment."

SECTION 39. G.S. 122C-287 reads as rewritten:

"**§ 122C-287. Disposition.**

The court may make one of the following dispositions:

(1) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance abuser and is dangerous to ~~himself~~ self or others, it shall order for a period not in excess of 180 days commitment to and treatment by an area ~~authority~~ facility or physician who is responsible for the management and supervision of the respondent's commitment and treatment. Before ordering commitment to and treatment by an area facility or a physician who is not a physician at an inpatient facility, the court shall follow the procedures specified in G.S. 122C-271(a)(3) and G.S. 122C-271(b)(4), as applicable. The court shall not order commitment to an area facility unless the respondent is eligible for services at the area facility through an LME/MCO or otherwise qualifies for the provision of services offered by the provider.

(2) If the court finds that the respondent does not meet the commitment criteria set out in subdivision (1) of this subsection, the respondent shall be discharged and the facility in which he was last treated so notified."

SECTION 40. G.S. 122C-290 reads as rewritten:

"**§ 122C-290. Duties for follow-up on commitment order.**

(a) The area ~~authority~~ facility or physician responsible for management and supervision of the respondent's commitment and treatment may prescribe or administer to the respondent reasonable and appropriate treatment either on an outpatient basis or in a 24-hour facility.

(b) If the respondent whose treatment is provided on an outpatient basis fails to comply with all or part of the prescribed treatment after reasonable effort to solicit the respondent's compliance or whose treatment is provided on an inpatient basis is discharged in accordance with G.S. 122C-205.1(b), the area ~~authority~~ facility or physician may request the clerk or magistrate to order the respondent taken into custody for the purpose of examination. Upon receipt of this request, the clerk or magistrate shall issue an order to a law enforcement officer to take the respondent into custody and to take him immediately to the designated area ~~authority~~ facility or physician for examination. The custody order is valid throughout the State. The law enforcement officer shall turn the respondent over to the custody of the physician or area ~~authority~~ facility who shall conduct the examination and release the respondent or have the

respondent taken to a 24-hour facility upon a determination that treatment in the facility will benefit the respondent. Transportation to the 24-hour facility shall be provided as specified in G.S. 122C-251, upon notice to the clerk or magistrate that transportation is necessary, or as provided in G.S. 122C-408(b). If placement in a 24-hour facility is to exceed 45 consecutive days, the area ~~authority~~ facility or physician shall notify the clerk of court by the 30th day and request a supplemental hearing as specified in G.S. 122C-291.

(c) If the respondent intends to move or moves to another county within the State, the area ~~authority~~ facility or physician shall notify the clerk of court in the county where the commitment is being supervised and request that a supplemental hearing be calendared.

(d) If the respondent moves to another state or to an unknown location, the designated area ~~authority~~ facility or physician shall notify the clerk of superior court of the county where the commitment is supervised and the commitment shall be terminated."

SECTION 41. G.S. 122C-291 reads as rewritten:

"**§ 122C-291. Supplemental hearings.**

(a) Upon receipt of a request for a supplemental hearing, the clerk shall calendar a hearing to be held within 14 days and notify, at least 72 hours before the hearing, the petitioner, the respondent, his attorney, if any, and the designated area ~~authority~~ facility or physician. Notice shall be provided in accordance with G.S. 122C-284(b). The procedures for the hearing shall follow G.S. 122C-286.

(b) At the supplemental hearing for a respondent who has moved or may move to another county, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent no longer meets the criteria for commitment, it shall discharge the respondent from the order and dismiss the case. If the court determines that the respondent continues to meet the criteria for commitment, it shall continue the commitment but shall designate an area ~~authority~~ facility or physician at the respondent's new residence to be responsible for the management or supervision of the respondent's commitment. The court shall order the respondent to appear for treatment at the address of the newly designated area ~~authority~~ facility or physician and shall order venue for further court proceedings under the commitment to be transferred to the new county of supervision. Upon an order changing venue, the clerk of court in the county where the commitment has been supervised shall transfer the records regarding the commitment to the clerk of court in the county where the commitment will be supervised. Also, the clerk of court in the county where the commitment has been supervised shall send a copy of the court's order directing the continuation of treatment under new supervision to the newly designated area ~~authority~~ facility or physician.

(c) At a supplemental hearing for a respondent to be held longer than 45 consecutive days in a 24-hour facility, the court shall determine if the respondent meets the criteria for commitment set out in G.S. 122C-283(d)(1). If the court determines that the respondent continues to meet the criteria and that further treatment in the 24-hour facility is necessary, the court may authorize continued care in the facility for not more than 90 days, after which a rehearing for the purpose of determining the need for continued care in the 24-hour facility shall be held, or the court may order the respondent released from the 24-hour facility and continued on the commitment on an outpatient basis. If the court determines that the respondent no longer meets the criteria for commitment the respondent shall be released and his case dismissed.

(d) At any time during the term of commitment order, a respondent may apply to the court for a supplemental hearing for the purpose of discharge from the order. The application shall be made in writing to the clerk of superior court. At the supplemental hearing the court shall determine whether the respondent continues to meet the criteria for commitment. The court may reissue or change the commitment order or discharge the respondent and dismiss the case."

SECTION 42. G.S. 122C-292 reads as rewritten:

"**§ 122C-292. Rehearings.**

(a) Fifteen days before the end of the initial or subsequent periods of commitment if the area ~~authority~~ facility or physician determines that the respondent continues to meet the criteria specified in G.S. 122C-283(d)(1), the clerk of superior court of the county where commitment is supervised shall be notified. The clerk, at least 10 days before the end of the commitment period, on order of the district court, shall calendar the rehearing. If the respondent no longer meets the criteria, the area ~~authority~~ facility or physician shall so notify the clerk who shall dismiss the case.

(b) Rehearings are governed by the same notice and procedures as initial hearings, and the respondent has the same rights ~~he had~~that were available to the respondent at the initial hearing including the right to appeal.

(c) If the court finds that the respondent no longer meets the criteria of G.S. 122C-283(d)(1), it shall unconditionally discharge him. A copy of the discharge order shall be furnished by the clerk to the designated area ~~authority~~ facility or physician. If the respondent continues to meet the criteria of G.S. 122C-283(d)(1), the court may order commitment for additional periods not in excess of 365 days each."

SECTION 43. G.S. 122C-293 reads as rewritten:

"**§ 122C-293. Release by area authority or physician.**

The area ~~authority~~ facility or physician as designated in the order shall discharge a committed respondent unconditionally at any time ~~he~~ the physician determines that the respondent no longer meets the criteria of G.S. 122C-283(d)(1). Notice of discharge and the reasons for the release shall be reported in writing to the clerk of superior court of the county in which the commitment was ordered."

SECTION 44. G.S. 122C-294 reads as rewritten:

"**§ 122C-294. Local plan.**

Each area authority shall develop a local plan in accordance with G.S. 122C-202.2 with local law-enforcement agencies, local courts, local hospitals, and ~~local medical societies~~others as necessary to facilitate implementation of this Part."

SECTION 45.(a) Each LME/MCO shall submit to the Department of Health and Human Services a copy of its current community crisis services plan adopted pursuant to G.S. 122C-202.2, as enacted by this act, by the earlier of (i) 12 months after the date the Department receives notification that the federal Centers for Medicaid and Medicare has approved all necessary waivers and State Plan amendments for Medicaid and NC Health Choice transformation as provided for in S.L. 2015-245, as amended, or (ii) six months prior to the date the Department actually initiates capitated contracts with Prepaid Health Plans, as defined in Section 4 of S.L. 2015-245, as amended, for the delivery of Medicaid and NC Health Choice services. The Department shall notify each LME/MCO when the earlier of these conditions occurs.

SECTION 45.(b) This section is effective when it becomes law.

SECTION 46. Except as otherwise provided, this act becomes effective December 1, 2017, and applies to proceedings initiated on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, April 26, 2017

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

FAVORABLE

SB **630** Revise IVC Laws to Improve Behavioral Health.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Ralph Hise will handle SB 630

Speaker Sign In

Name	Company/ Phone number
Mark Botts	UNC - School of Gov't 919-962-8204 botts@sog.unc.edu

Brian Mooney

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 26, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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[illegible]	[illegible]
Jon Carr	Jordan Price
Steve Mitchell	Astellas
Sarah McQuillan	KOANC
Daly Whiteside	Office of Indigent Defense Services
Steven Coburn	Clerk's Cmty.
Jamie Lassiter	Conf. of Clerks
Sarah Collins	NCSM
Dyde Ferfer	CCR
[illegible] Parkinson	Parkinson Law
Fred [illegible]	Boyce & Assoc.
McNair Merritt	Gov't Relations
Nate Mutcher	[illegible]
[illegible]	[illegible]
Wendy Kelly	Town Carolina

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 26, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Amanda Donovan	KTS
Corye Dunn	DRNC
NICHOLE KARAM	NAMI NC
Jake Spee	NCPPC
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[illegible]	[illegible]
Jodi Maynard	OPUS 8800
Colleen Cochonek	NCCEP
Ben Popken	DHHS

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 26, 2017

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Christine Craig	WakeMed
Ryan Blackledge	ConnHealth
Daniel VanLiere	Vidant Health
JERRY COHEN	NM
Carla G. Yancey	NCANP
Hugh Johnson	NCAFP
Jai Kumar	NCHA
Sue Ann Forrest	NCMS
Skip Bassett	ACMS
Andy Munn	MVA
Jarod Bales	Brubaker & Associates
John Del Giorno	" "
PEYTON MAYNARD	
Darryl Childers	Governor's Office
Mike James	
Jennifer Turner	BCBSNC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

April 26, 2017

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NAME	FIRM OR AGENCY AND ADDRESS
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
Jill Barnhart	MWC
J Peters	CSS
H F Tedder	NSTA Strategies
Krista Rag	DMH/DD/SAS
Kari Barsness	Gateway Health
LT McCrimmon	DHHS

09-21-201

Senate Committee on Health Care
Thursday, May 18, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on May 18, 2017, in Room 643 of the Legislative Office Building. Fifteen members were present.

Sen. Ralph Hise, Chair, presided.

Sen. Hise opened the meeting by recognizing the pages–Makenzie Waites of Raleigh, Cassi Phillips of Spruce Pine, Anna Conger of Raleigh, Joshua Dellinger of Maiden, Brenna Daniel of Morganton, and Ariana Daniels of Winston-Salem. He also recognized the Sergeants-at-Arms, Jim Hamilton, Charles Marsalis, and Steve McKaig.

Sen. Hise recognized Rep. Szoka to present HB 57–Enact Physical Therapy Licensure Compact. Sen. Wells offered an amendment to the bill. Sen. Newton moved for adoption of the amendment; the motion passed. Sen. Lowe moved for a favorable report to the amended bill rolled into a PCS. The motion passed.

Rep. Dobson was recognized to present HB 299–State Health Plan Administrative Changes.-AB. Sen. Krawiec offered an amendment and moved for adoption of the amendment; the motion passed. Sen. J. Davis moved for a favorable report of the amended bill rolled into a PCS. The motion passed.

Rep. Dobson was recognized to present HB 478–Required Experience for MH/DD/SAS QPs. Sen. Krawiec offered an amendment which was adopted. Sen. J. Davis moved for a favorable report of the amended bill rolled into a PCS. The motion passed.

Sen. Pate chaired while Sen. Hise presented HB 657–Improve Adult Care Home Regulation. Sen. D. Davis moved for a favorable report to the bill. The motion passed.

Sen. Newton was recognized to present HB 208–Occup. Therapy/Choice of Provider. Sen. Tucker moved for a favorable report to the bill. The motion passed.

The meeting adjourned at 10:40 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
Thursday	May 18, 2017	10:00 AM	643 LOB

Agenda to be determined.

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

Principal Clerk ____
Reading Clerk ____

Corrected #1:

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	May 18, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 57	Enact Physical Therapy Licensure Compact.	Representative Szoka Representative G. Martin Representative Grange
HB 283	DHHS Recommend Telemedicine Policy.	Representative Lambeth Representative Insko Representative Murphy Representative Dobson
HB 299	State Health Plan Administrative Changes.-AB	Representative Dobson Representative Corbin Representative Clampitt Representative Henson
HB 478	Required Experience for MH/DD/SAS QPs.	Representative Dobson Representative S. Martin Representative K. Hall Representative Brisson
HB 657	Improve Adult Care Home Regulation.	Representative Burr Representative Dobson Representative White Representative Sauls

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

Principal Clerk ____
Reading Clerk ____

Corrected #2: HB 208 has been added. HB 283 has been removed.

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Thursday	May 18, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 57	Enact Physical Therapy Licensure Compact.	Representative Szoka Representative G. Martin Representative Grange
HB 299	State Health Plan Administrative Changes.-AB	Representative Dobson Representative Corbin Representative Clampitt Representative Henson
HB 478	Required Experience for MH/DD/SAS QPs.	Representative Dobson Representative S. Martin Representative K. Hall Representative Brisson
HB 657	Improve Adult Care Home Regulation.	Representative Burr Representative Dobson Representative White Representative Sauls
HB 208	Occup. Therapy/Choice of Provider.	Representative Blackwell Representative Murphy Representative Setzer Representative Hurley

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

Senate Committee on Health Care
Thursday, May 18, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Senator Hise, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 57	Enact Physical Therapy Licensure Compact.	Representative Szoka Representative G. Martin Representative Grange
HB 299	State Health Plan Administrative Changes.-AB	Representative Dobson Representative Corbin Representative Clampitt Representative Henson
HB 478	Required Experience for MH/DD/SAS QPs.	Representative Dobson Representative S. Martin Representative K. Hall Representative Brisson
HB 657	Improve Adult Care Home Regulation.	Representative Burr Representative Dobson Representative White Representative Sauls
HB 208	Occup. Therapy/Choice of Provider.	Representative Blackwell Representative Murphy Representative Setzer Representative Hurley

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, May 18, 2017

Senator Hise,
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 **57** **(CS#2)** Enact Physical Therapy Licensure Compact.

Draft Number:	H57-PCS30414-BCf-26
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Andy Wells will handle HB 57

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, May 18, 2017

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

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

HB **299** State Health Plan Administrative Changes.-AB

Draft Number:	H299-PCS40575-SH-23
Sequential Referral:	Pensions and Retirement and Aging
Recommended Referral:	None
Long Title Amended:	No

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

HB **478** **(CS#1)** Required Experience for MH/DD/SAS QPs.

Draft Number:	H478-PCS40573-TY-18
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Joyce Krawiec will handle HB 299
Senator Joyce Krawiec will handle HB 478

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, May 18, 2017

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

FAVORABLE

HB **208** Occup. Therapy/Choice of Provider.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

HB **657** **(CS#1)** Improve Adult Care Home Regulation.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Paul Newton will handle HB 208
Senator Ralph Hise will handle HB 657

HOUSE BILL 57:
Enact Physical Therapy Licensure Compact.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 18, 2017
Introduced by:	Reps. Szoka, G. Martin, Grange	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	Third Edition		

OVERVIEW: ***House Bill 57 would make North Carolina a member of the Physical Therapy Licensure Compact. Membership in the compact would allow physical therapists who hold licenses in good standing in any other Compact state to practice physical therapy in North Carolina. Likewise, physical therapists holding a valid license in North Carolina would be able to practice physical therapy in any of other the Compact member states. The Compact will become effective when the tenth member state enacts it.***

CURRENT LAW: Under current law, individuals who hold a license to practice physical therapy in another state must go through the process to be licensed by endorsement before being allowed to practice in North Carolina. This process involves submitting an application and application fee, verifying licensure in the other state, and verifying a score of at least 600 or higher on the National Physical Therapy Exam. Once the North Carolina license is granted, the physical therapist must comply with all of North Carolina's requirements in order to maintain the license, in addition to complying with the requirements to maintain a license in any other state in which the therapist is licensed.

BILL ANALYSIS:

Section 1 of the bill recodifies Article 18B of Chapter 90 of the General Statutes, the current Physical Therapy Practice Act, as Article 18E of Chapter 90 of the General Statutes.

Section 2 of the bill creates Article 18F in Chapter 90 of the General Statutes, enacting the Physical Therapy Licensure Compact. In broad terms, physical therapists licensed in a Compact state would hold and maintain a license in their home state and be licensed to practice physical therapy in any Compact member state. The home state's laws and regulations would govern the therapist's maintenance of the license in the therapist's home state. If the therapist lost the license held in the home state, the therapist would no longer be licensed to practice in any of the Compact member states. Any therapist practicing in North Carolina under the terms of the Compact would be bound by North Carolina laws and regulations.

G.S. 90-270.120 sets forth the purpose of the Physical Therapist Licensure Compact.

G.S. 90-270.121 lists the definitions to be used in Article 18F.

G.S. 90-270.122 would require states participating in the Compact to: 1) participate fully in the Compact's data system, 2) have a mechanism to receive and investigate complaints about licensees, 3) notify the Compact Commission of any disciplinary action taken against a licensee, 4) fully implement a criminal background check requirement, 5) comply with the rules promulgated by the Compact Commission, 6) use a nationally recognized exam as a basis for licensure, and 7) establish continuing competence requirements. In addition, member states would have the authority to collect biometric data from each license applicant and to charge a fee for granting a compact privilege.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

G.S. 90-270.123 would require individuals licensed under the Compact to: 1) hold a license in their home state, 2) not have encumbrances on any license in any state, 3) be eligible for Compact privileges in accordance with Article 18F, 4) not had adverse action against any license in the last two years, 5) notify the Commission the applicant is seeking privileges within another state, 6) pay applicable fees, 7) meet any jurisprudence requirements of the remote state, and 8) report adverse action taken against the licensee to the Commission within 30 days. G.S. 90-270.123 also states that the Compact privilege is valid only as long as the individual's license in the home state is valid. Licensees are required to follow all the laws, regulations, and regulatory authority of the remote state when practicing in the remote state. The process for restoring lost Compact privileges is also set forth.

G.S. 90-270.124 would allow active duty military members or their spouses to designate their home state as their home of record, their Permanent Change of Station location, or their state of current residence or duty station if either is different than the Permanent Change of Station or home of record.

G.S. 270.125 states that although the home state has the exclusive authority to take adverse action against a home state license, it may take action based on the recommendations and investigations of a remote state. Remote states have the power to investigate complaints and initiate adverse action against licensees in the remote state. Member states may also jointly investigate complaints.

G.S. 90-270.126 would establish the Physical Therapy Compact Commission, which is the governing body of the Compact. The Commission is comprised of one delegate from each Compact state and must meet regularly, in public, to carry out the business of the Compact. It does not have the power to change the laws and regulations of the member states. G.S. 90-270.126 also establishes the Executive Board, which has the power to act on behalf of the Commission. The Board is comprised of seven voting members selected from the current membership of the Commission and two non-voting members from physical therapy organizations. The members of the Executive Board are immune from suit against them personally for their official actions.

G.S. 90-270.127 would establish a data system to be shared among the member states. This system can be accessed by any member state. Each member state must submit the following information on licensees to the system: 1) identifying information, 2) licensure data, 3) adverse actions, 4) non-confidential information related to alternative program participation, 5) information on denials of applications for licensure, and 6) other information determined by the Commission. Member states may designate certain information that will remain confidential. The Commission is required to notify all member states of any adverse action taken against a licensee.

G.S. 90-270.128 would set forth the Commission's authority to make rules for the Compact and the process to promulgate those rules. The Commission does not have any authority to change individual states' rules of practice for physical therapists. Prospective Commission rules are subject to a notice and comment period before being voted on by the Commission at a regular or special meeting. A public hearing will be held if requested by at least 25 people, a state or federal government agency, or an association of at least 25 members. If a majority of the legislatures of the Compact member states reject a rule by enactment of a statute or resolution, the rule will have no further effect in any member state.

G.S. 90-270.129 would provide for enforcement of the Compact by all three branches of state government. It would allow the Commission to be an intervening party in any suit affecting the powers, responsibilities, or actions of the Commission. The Commission may terminate a member state from the Compact if it determines the member state is in default of its obligations under the Compact. Termination will be undertaken only as a last resort if no other method of securing compliance with the Compact has been effective. Disputes between member and non-member states relating to the Compact will be resolved by the Commission.

G.S. 90-270.130 states the Compact will come into effect on the date the tenth member state enacts it into law. Member states can withdraw from the Compact by enacting a statute repealing the original enacting statute. Amendments to the Compact may be enacted by member states, but amendments will not be effective until they have been enacted into law by all the member states.

G.S. 90-270.131 states that the provisions of the Compact are severable, and any provisions not specifically struck down by a court will remain in effect.

EFFECTIVE DATE: This bill would become effective October 1, 2017.

BACKGROUND: This act streamlines the process for physical therapists licensed in other states to become eligible to practice in North Carolina. It is similar in structure and effect to the Nurse Licensure Compact (Article 9G of Chapter 90), which was enacted in 1999.

As of May 17, 2017, the Physical Therapy Compact has been enacted in Arizona, Kentucky, Mississippi, Missouri, Montana, North Dakota, Oregon, Tennessee, Utah, and Washington. Legislation has been introduced in Colorado, Florida, Illinois, New Hampshire, New Jersey, Oklahoma, and Texas.

Trina Griffin of the Legislative Analysis Division contributed to this summary.

HOUSE BILL 57
Committee Substitute Favorable 2/15/17
Committee Substitute #2 Favorable 2/23/17

Short Title: Enact Physical Therapy Licensure Compact. (Public)

Sponsors:

Referred to:

February 8, 2017

A BILL TO BE ENTITLED

AN ACT ESTABLISHING A PHYSICAL THERAPY LICENSURE COMPACT TO FACILITATE THE INTERSTATE PRACTICE OF PHYSICAL THERAPY.

The General Assembly of North Carolina enacts:

SECTION 1. Article 18B of Chapter 90 of the General Statutes, G.S. 90-270.24 through G.S. 90-270.44, is recodified as Article 18E of Chapter 90 of the General Statutes, G.S. 90-270.90 through G.S. 90-270.110.

SECTION 2. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18F.

"Physical Therapy Licensure Compact.

"**§ 90-270.120. Purpose.**

The purpose of this Compact is to facilitate the interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure. This Compact is designed to achieve the following objectives:

(1) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses.
(2) Enhance the states' ability to protect the public's health and safety.
(3) Encourage the cooperation of member states in regulating multistate physical therapy practice.
(4) Support spouses of relocating military members.
(5) Enhance the exchange of licensure, investigative, and disciplinary information between member states.
(6) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

"**§ 90-270.121. Definitions.**

As used in this Compact, and except as otherwise provided, the following definitions apply:

(1) Active duty military. – Full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Section 1209 and 1211.

(2) Adverse action. – Disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.

(3) Alternative program. – A non-disciplinary monitoring or practice remediation process approved by a physical therapy licensing board. This includes, but is not limited to, substance abuse issues.

(4) Compact privilege. – The authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

(5) Continuing competence. – A requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

(6) Data system. – A repository of information about licensees, including examination, licensure, investigative, compact privilege, and adverse action.

(7) Encumbered license. – A license that a physical therapy licensing board has limited in any way.

(8) Executive board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(9) Home state. – The member state that is the licensee's primary state of residence.

(10) Investigative information. – Information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.

(11) Jurisprudence requirement. – The assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a state.

(12) Licensee. – An individual who currently holds an authorization from the state to practice as a physical therapist or to work as a physical therapist assistant.

(13) Member state. – A state that has enacted the Compact. For purposes of this Article, the State of North Carolina may designate the North Carolina Board of Physical Therapy Examiners as the entity responsible for carrying out any action required by or of a member state under this Article, including the imposition of fees or the payment of assessments.

(14) Party state. – Any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.

(15) Physical therapist. – An individual who is licensed by a state to practice physical therapy.

(16) Physical therapist assistant. – An individual who is licensed/certified by a state and who assists the physical therapist in selected components of physical therapy.

(17) Physical therapy, physical therapy practice, or the practice of physical therapy. – The care and services provided by or under the direction and supervision of a licensed physical therapist.

(18) Physical Therapy Compact Commission or Commission. – The national administrative body whose membership consists of all states that have enacted the Compact.

(19) Physical Therapy Licensing Board or Licensing Board. – The agency that is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

(20) Remote state. – A member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

(21) Rule. – A regulation, principle, or directive promulgated by the Commission that has the force of law.

(22) State. – Any state, commonwealth, district, or territory of the United States of America that regulates the practice of physical therapy.

"**§ 90-270.122. State participation in the compact.**

(a) To participate in the Compact, a state must do all of the following:

(1) Participate fully in the Commission's data system, including using the Commission's unique identifier as defined in rules.

(2) Have a mechanism in place for receiving and investigating complaints about licensees.

(3) Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee.

(4) Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions in accordance with subsection (b) of this section.

(5) Comply with the rules of the Commission.

(6) Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the Commission.

(7) Have continuing competence requirements as a condition for license renewal.

(b) Upon adoption of this statute, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. § 534 and 42 U.S.C. § 14616.

(c) A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the Compact and rules.

(d) Member states may charge a fee for granting a compact privilege.

"**§ 90-270.123. Compact privilege.**

(a) In order to exercise the compact privilege under the terms and provisions of the Compact, the licensee shall meet all of the following qualifications:

(1) Hold a license in the home state.

(2) Have no encumbrance on any state license.

(3) Be eligible for a compact privilege in any member state in accordance with subsections (d), (g) and (h) of this section.

(4) Have not had any adverse action against any license or compact privilege within the previous two years.

(5) Notify the Commission that the licensee is seeking the compact privilege within a remote state(s).

(6) Pay any applicable fees, including any state fee, for the compact privilege.

(7) Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege.

(8) Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

(b) The compact privilege is valid until the expiration date of the home license. The licensee must comply with the requirements of subsection (a) of this section to maintain the compact privilege in the remote state.

(c) A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

(d) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

(e) If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until both of the following occur:

(1) The home state license is no longer encumbered.

(2) Two years have elapsed from the date of the adverse action.

(f) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (a) of this section to obtain a compact privilege in any remote state.

(g) If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until all of the following occur:

(1) The specific period of time for which the compact privilege was removed has ended.

(2) All fines have been paid.

(3) Two years have elapsed from the date of the adverse action.

(h) Once the requirements of subsection (g) of this section have been met, the license must meet the requirements in subsection (a) of this section to obtain a compact privilege in a remote state.

"**§ 90-270.124. Active duty military personnel or their spouses.**

A licensee who is active duty military or is the spouse of an individual who is active duty military may designate one of the following as the home state:

(1) Home of record.

(2) State listed on Permanent Change of Station (PCS) order.

(3) State of current residence or duty station if it is different than the PCS state or home of record.

"**§ 90-270.125. Adverse actions.**

(a) A home state shall have exclusive power to impose adverse action against a license issued by the home state.

(b) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

(c) Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

(d) Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.

(e) A remote state shall have the authority to do all of the following:

(1) Take adverse actions as set forth in subsection (d) of G.S. 90-270.123 against a licensee's compact privilege in the state.

(2) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction,

according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(3) If otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.

(f) Joint Investigations. –

(1) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

(2) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

"**§ 90-270.126. Establishment of the Physical Therapy Compact Commission.**

(a) The Compact member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

(1) The Commission is an instrumentality of the Compact states.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) Each member state shall have and be limited to one delegate selected by that member state's licensing board.

(2) The delegate shall be a current member of the licensing board, who is a physical therapist, physical therapist assistant, public member, or the board administrator.

(3) Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

(4) The member state board shall fill any vacancy occurring in the Commission.

(5) Each delegate shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission.

(6) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(7) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

(c) The Commission shall have all of the following powers and duties:

(1) Establish the fiscal year of the Commission.

(2) Establish bylaws.

(3) Maintain its financial records in accordance with the bylaws.

(4) Meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

(5) Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states.

(6) Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law shall not be affected.
(7) Purchase and maintain insurance and bonds.
(8) Borrow, accept, or contract for services of personnel, including employees of a member state.
(9) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to (i) carry out the purposes of the Compact and (ii) establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.
(10) Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest.
(11) Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety.
(12) Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed.
(13) Establish a budget and make expenditures.
(14) Borrow money.
(15) Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws.
(16) Provide and receive information from, and cooperate with, law enforcement agencies.
(17) Establish and elect an Executive Board.
(18) Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of physical therapy licensure and practice.

(d) The Executive Board. –

The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact:

(1) The Executive Board shall be composed of the following nine members:
  (a) Seven voting members who are elected by the Commission from the current membership of the Commission.
  (b) One ex-officio, nonvoting member from the recognized national physical therapy professional association.
  (c) One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.
(2) The ex-officio members will be selected by their respective organizations.
(3) The Commission may remove any member of the Executive Board as provided in bylaws.
(4) The Executive Board shall meet at least annually.
(5) The Executive Board shall have all of the following Duties and responsibilities:
  a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by Compact member states such as annual dues, and any commission Compact fee charged to licensees for the compact privilege.

b. Ensure Compact administration services are appropriately provided, contractual or otherwise.
c. Prepare and recommend the budget.
d. Maintain financial records on behalf of the Commission.
e. Monitor Compact compliance of member states and provide compliance reports to the Commission.
f. Establish additional committees as necessary.
g. Other duties as provided in rules or bylaws.

(e) Meetings of the Commission. –

(1) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.128.

(2) The Commission or the Executive Board or other committees of the Commission may convene in a closed, nonpublic meeting if the Commission or Executive Board or other committees of the Commission must discuss any of the following:

a. Noncompliance of a member state with its obligations under the Compact.
b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures.
c. Current, threatened, or reasonably anticipated litigation.
d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.
e. Accusing any person of a crime or formally censuring any person.
f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential.
g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy.
h. Disclosure of investigative records compiled for law enforcement purposes.
i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact.
j. Matters specifically exempted from disclosure by federal or member state statute.

(3) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

(4) The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

(f) Financing of the Commission. –

(1) The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.127. Data system.**

(a) The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

(b) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including all of the following:

(1) Identifying information.
(2) Licensure data.
(3) Adverse actions against a license or compact privilege.
(4) Non-confidential information related to alternative program participation.
(5) Any denial of application for licensure, and the reason(s) for such denial.
(6) Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

(c) Investigative information pertaining to a licensee in any member state will only be available to other party states.

(d) The Commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

(e) Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

(f) Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

"**§ 90-270.128. Rule Making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four years of the date of adoption of the rule, then such rule shall have no further force and effect in any member state.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or rules by the Commission, and at least 30 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making on both of the following:

(1) On the Web site of the Commission or other publicly accessible platform.
(2) On the Web site of each member state physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include all of the following:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon.
(2) The text of the proposed rule or amendment and the reason for the proposed rule.
(3) A request for comments on the proposed rule from any interested person.
(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by any of the following:

(1) At least 25 persons.
(2) A state or federal governmental subdivision or agency.
(3) An association having at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

(1) All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.
(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
(3) All hearings will be recorded. A copy of the recording will be made available on request.
(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(k) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to do any of the following:

(1) Meet an imminent threat to public health, safety, or welfare.
(2) Prevent a loss of Commission or member state funds.
(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.
(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.129. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of

this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall do all of the following:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission.

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(4) A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(5) The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.130. Date of implementation of the interstate Commission for Physical Therapy Practice and associated rules, withdrawal and amendment.**

(a) The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any member state may withdraw from this Compact by enacting a statute repealing the same.

(1) A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

"**§ 90-270.131. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters."

SECTION 3. This act becomes effective October 1, 2017. The North Carolina Board of Physical Therapy Examiners shall report to the Revisor of Statutes when the Physical Therapy Licensure Compact has been enacted by the tenth member state.

HOUSE BILL 57:
Enact Physical Therapy Licensure Compact.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 18, 2017
Introduced by:	Reps. Szoka, G. Martin, Grange	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	Third Edition		

OVERVIEW: ***House Bill 57 would make North Carolina a member of the Physical Therapy Licensure Compact. Membership in the compact would allow physical therapists who hold licenses in good standing in any other Compact state to practice physical therapy in North Carolina. Likewise, physical therapists holding a valid license in North Carolina would be able to practice physical therapy in any of other the Compact member states. The Compact will become effective when the tenth member state enacts it.***

CURRENT LAW: Under current law, individuals who hold a license to practice physical therapy in another state must go through the process to be licensed by endorsement before being allowed to practice in North Carolina. This process involves submitting an application and application fee, verifying licensure in the other state, and verifying a score of at least 600 or higher on the National Physical Therapy Exam. Once the North Carolina license is granted, the physical therapist must comply with all of North Carolina's requirements in order to maintain the license, in addition to complying with the requirements to maintain a license in any other state in which the therapist is licensed.

BILL ANALYSIS:

Section 1 of the bill recodifies Article 18B of Chapter 90 of the General Statutes, the current Physical Therapy Practice Act, as Article 18E of Chapter 90 of the General Statutes.

Section 2 of the bill creates Article 18F in Chapter 90 of the General Statutes, enacting the Physical Therapy Licensure Compact. In broad terms, physical therapists licensed in a Compact state would hold and maintain a license in their home state and be licensed to practice physical therapy in any Compact member state. The home state's laws and regulations would govern the therapist's maintenance of the license in the therapist's home state. If the therapist lost the license held in the home state, the therapist would no longer be licensed to practice in any of the Compact member states. Any therapist practicing in North Carolina under the terms of the Compact would be bound by North Carolina laws and regulations.

G.S. 90-270.120 sets forth the purpose of the Physical Therapist Licensure Compact.

G.S. 90-270.121 lists the definitions to be used in Article 18F.

G.S. 90-270.122 would require states participating in the Compact to: 1) participate fully in the Compact's data system, 2) have a mechanism to receive and investigate complaints about licensees, 3) notify the Compact Commission of any disciplinary action taken against a licensee, 4) fully implement a criminal background check requirement, 5) comply with the rules promulgated by the Compact Commission, 6) use a nationally recognized exam as a basis for licensure, and 7) establish continuing competence requirements. In addition, member states would have the authority to collect biometric data from each license applicant and to charge a fee for granting a compact privilege.

Karen Cochrane-Brown
Director

H57-SMBC-66 E3 -V-2

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

G.S. 90-270.123 would require individuals licensed under the Compact to: 1) hold a license in their home state, 2) not have encumbrances on any license in any state, 3) be eligible for Compact privileges in accordance with Article 18F, 4) not had adverse action against any license in the last two years, 5) notify the Commission the applicant is seeking privileges within another state, 6) pay applicable fees, 7) meet any jurisprudence requirements of the remote state, and 8) report adverse action taken against the licensee to the Commission within 30 days. G.S. 90-270.123 also states that the Compact privilege is valid only as long as the individual's license in the home state is valid. Licensees are required to follow all the laws, regulations, and regulatory authority of the remote state when practicing in the remote state. The process for restoring lost Compact privileges is also set forth.

G.S. 90-270.124 would allow active duty military members or their spouses to designate their home state as their home of record, their Permanent Change of Station location, or their state of current residence or duty station if either is different than the Permanent Change of Station or home of record.

G.S. 270.125 states that although the home state has the exclusive authority to take adverse action against a home state license, it may take action based on the recommendations and investigations of a remote state. Remote states have the power to investigate complaints and initiate adverse action against licensees in the remote state. Member states may also jointly investigate complaints.

G.S. 90-270.126 would establish the Physical Therapy Compact Commission, which is the governing body of the Compact. The Commission is comprised of one delegate from each Compact state and must meet regularly, in public, to carry out the business of the Compact. It does not have the power to change the laws and regulations of the member states. G.S. 90-270.126 also establishes the Executive Board, which has the power to act on behalf of the Commission. The Board is comprised of seven voting members selected from the current membership of the Commission and two non-voting members from physical therapy organizations. The members of the Executive Board are immune from suit against them personally for their official actions.

G.S. 90-270.127 would establish a data system to be shared among the member states. This system can be accessed by any member state. Each member state must submit the following information on licensees to the system: 1) identifying information, 2) licensure data, 3) adverse actions, 4) non-confidential information related to alternative program participation, 5) information on denials of applications for licensure, and 6) other information determined by the Commission. Member states may designate certain information that will remain confidential. The Commission is required to notify all member states of any adverse action taken against a licensee.

G.S. 90-270.128 would set forth the Commission's authority to make rules for the Compact and the process to promulgate those rules. The Commission does not have any authority to change individual states' rules of practice for physical therapists. Prospective Commission rules are subject to a notice and comment period before being voted on by the Commission at a regular or special meeting. A public hearing will be held if requested by at least 25 people, a state or federal government agency, or an association of at least 25 members. If a majority of the legislatures of the Compact member states reject a rule by enactment of a statute or resolution, the rule will have no further effect in any member state.

G.S. 90-270.129 would provide for enforcement of the Compact by all three branches of state government. It would allow the Commission to be an intervening party in any suit affecting the powers, responsibilities, or actions of the Commission. The Commission may terminate a member state from the Compact if it determines the member state is in default of its obligations under the Compact. Termination will be undertaken only as a last resort if no other method of securing compliance with the Compact has been effective. Disputes between member and non-member states relating to the Compact will be resolved by the Commission.

G.S. 90-270.130 states the Compact will come into effect on the date the tenth member state enacts it into law. Member states can withdraw from the Compact by enacting a statute repealing the original enacting statute. Amendments to the Compact may be enacted by member states, but amendments will not be effective until they have been enacted into law by all the member states.

G.S. 90-270.131 states that the provisions of the Compact are severable, and any provisions not specifically struck down by a court will remain in effect.

EFFECTIVE DATE: This bill would become effective October 1, 2017.

BACKGROUND: This act streamlines the process for physical therapists licensed in other states to become eligible to practice in North Carolina. It is similar in structure and effect to the Nurse Licensure Compact (Article 9G of Chapter 90), which was enacted in 1999.

As of May 17, 2017, the Physical Therapy Compact has been enacted in Arizona, Kentucky, Mississippi, Missouri, Montana, North Dakota, Oregon, Tennessee, Utah, and Washington. Legislation has been introduced in Colorado, Florida, Illinois, New Hampshire, New Jersey, Oklahoma, and Texas.

Trina Griffin of the Legislative Analysis Division contributed to this summary.

HOUSE BILL 57:
Occ. Lic. Protection.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 18, 2017
Introduced by:	Reps. Szoka, G. Martin, Grange	**Prepared by:**	Jason Moran-Bates
Analysis of:	Amendment to Third Edition H57-ABC-20		Committee Co-Counsel

OVERVIEW: ***Amendment H57-ABC-20 to House Bill 57 would amend G.S. 93B-15.1 to prohibit occupational licensing boards (OLBs), as defined in G.S. 93B-1, from charging fees as a pre-requisite to issuing licenses to military-trained applicants and spouses of military members who are licensed in good standing in another state. The Amendment would also clarify the length of time for which temporary practice permits are valid.***

CURRENT LAW: Currently, G.S. 93B-15.1 allows OLBs to charge application fees to military-trained applicants and spouses of military members.

BILL ANALYSIS: The Amendment to House Bill 57 would amend G.S. 93B-15.1(a) and (b) to prohibit OLBs from requiring payment of any fees as a pre-requisite to issuing a license to a military-trained applicant or spouse of a military member. The Amendment would require applicants and spouses to not have any pending complaints against their licenses in the state in which they are licensed. In addition, the Amendment would amend G.S. 93B-15.1(f) to make temporary practice permits granted to military-trained applicants or spouses valid for either one year or until the required renewal date for the occupation for which the permit was issued, whichever is later. OLBs would be prohibited from charging application fees for any license, certification, registration, or temporary permit issued pursuant to G.S. 93B-15.1.

EFFECTIVE DATE: The Amendment to House Bill 57 would become effective July 1, 2017, and apply to applications received on or after that date.

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 57

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

H57-ABC-20 [v.3]

Amends Title [YES]
Third Edition

Date 5/18/17 ,2017

Senator Wells

moves to amend the bill on page 1, line 3, by rewriting the line to read:
"FACILITATE THE INTERSTATE PRACTICE OF PHYSICAL THERAPY AND EASING OCCUPATIONAL LICENSING BURDENS ON MILITARY FAMILIES";

and on page 12, lines 47-49, by rewriting the lines to read:

"**SECTION 3.** G.S. 93B-15.1 reads as rewritten:

"**§ 93B-15.1. Licensure for individuals with military training and experience; proficiency examination; licensure by endorsement for military spouses; temporary license.**

(a) Except as provided by subsection (a2) of this section, and notwithstanding any other provision of law, an occupational licensing board, as defined in G.S. 93B-1, shall issue a license, certification, or registration to a military-trained applicant to allow the applicant to lawfully practice the applicant's occupation in this State if, upon application to an occupational licensing board, the applicant satisfies the following conditions:

...

(3) Has not committed any act in any jurisdiction that would have constituted grounds for refusal, suspension, or revocation of a license to practice that occupation in this State at the time the act was ~~committed.~~committed, and has no pending complaints.

~~(4) Pays any fees required by the occupational licensing board for which the applicant is seeking licensure, certification, or registration in this State.~~

...

(b) Notwithstanding any other provision of law, an occupational licensing board, as defined in G.S. 93B-1, shall issue a license, certification, or registration to a military spouse to allow the military spouse to lawfully practice the military spouse's occupation in this State if, upon application to an occupational licensing board, the military spouse satisfies the following conditions:

...

(4) Is in good ~~standing and~~ standing; has not been disciplined by the agency that had jurisdiction to issue the license, certification, or ~~permit.~~permit; and has no pending complaints.

~~(5) Pays any fees required by the occupational licensing board for which the applicant is seeking licensure, certification, or registration in this State.~~

...

(f) An occupational licensing board ~~may~~ shall issue a temporary practice permit to a military-trained applicant or military spouse licensed, certified, or registered in another jurisdiction while the military-trained applicant or military spouse is satisfying the requirements for licensure under subsection (a) or (b) of this section if that jurisdiction has licensure, certification, or registration standards substantially equivalent to the standards for licensure, certification, or registration of an occupation licensing board in this State. The ~~military-trained applicant or military spouse may practice under the~~ temporary permit shall remain valid for the later of one year or the required renewal date for the occupation the temporary practice permit was issued for or until a license, certification, or registration is granted ~~or until a notice to deny a license, certification, or registration is issued in accordance with rules adopted~~ by the occupational licensing board.

...

(k) An occupational licensing board shall not charge a military-trained applicant or a military spouse an initial application fee for a license, certification, registration, or temporary practice permit issued pursuant to this section. Nothing in this subsection shall be construed to prohibit an occupational licensing board from charging its ordinary fee for a renewal application, or prohibit a third party from charging actual costs for a service such as a background check."

"**SECTION 4.** Sections 1 and 2 become effective October 1, 2017. The North Carolina Board of Physical Therapy Examiners shall report to the Revisor of Statutes when the Physical Therapy Licensure Compact has been enacted by the tenth member state. Section 3 becomes effective July 1, 2017, and applies to applications submitted on or after that date."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 299:
State Health Plan Administrative Changes.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 17, 2017
Introduced by:	Reps. Dobson, Corbin, Clampitt, Henson	**Prepared by:**	Theresa Matula
Analysis of:	First Edition		Committee Staff

House Bill 299 would make administrative changes to statutes governing the North Carolina State Health Plan for Teachers and State Employees (Plan) that: 1) allow revocation of coverage for misrepresentations made by covered individuals regarding eligibility or enrollment; 2) pertain to the premium split between the State and certain General Assembly retirees; 3) provide coverage to children newly born to existing covered employees; 4) prioritize the order in which excess funds in the Public Employee Health Benefit Fund are used; 5) grant powers to the Board of Trustees and State Treasurer pertaining to the unfunded actuarial liability; and 6) provide members of the Board of Trustees with immunity from civil liability for most actions taken in their official capacity.

[As introduced, this bill was identical to S218, as introduced by Sens. Krawiec, Pate, and Hise, which is currently in Senate Appropriations on Pensions, Compensation and Benefits. S218 was heard in Senate Health on 4/6/2019 and a PCS received a favorable report.]

CURRENT LAW: Where appropriate, the current law has been provided in italics below.

BILL ANALYSIS:

Section 1 would amend the statutes [G.S. 135-48.44(a)(6)] to clarify that an individual would lose coverage under the plan on the last day of the month the individual is found to have made a false representation of a material fact regarding eligibility or enrollment information.

Currently, individuals lose coverage only if they make false representations of material facts in a claim for reimbursement.

Section 2 would amend the law [G.S. 135-48.40(c)(2)] to provide that a retiree's premium for one-half contributory coverage is half of the employer contribution established by the General Assembly plus the employee contribution, clarifying that individual retirees must pay the balance of the total premiums not paid by the State unless prohibited by law. The section also amends the law [G.S. 135-48.40(c)(2)] to define "total premium" as the sum of the Plan's employer contribution rate and the employee or retiree's contribution rate.

Current law does not include the "unless prohibited by law" exception to the premium split or define the term "total premium."

Section 3 would amend the law [G.S. 135-48.42(a)] pertaining to enrollment to clarify that children born to covered employees will be covered from birth as long as the participants notify the Plan within 30 days of birth and pay premiums retroactive to the first day of the month in which the child was born.

Section 4 would amend the statutes [G.S. 135-48.5(a)], creating two health benefit trust funds, the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund, to clarify the order for using funds

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

in the Public Employee Health Benefit Fund that are in excess of the amount needed to pay benefit and administrative costs. The excess funds shall be used in the following order:

- First, to establish a reserve for incurred but unpresented claims.
- Second, to be set aside to reduce the Plan's unfunded actuarial accrued liability for post-employment retiree health benefits. Any amount set aside must be approved by the Board of Trustees and limited to no more than 50% of the excess funds in the Public Employee Health Benefit Fund after establishing a reserve for incurred but unpresented claims.
- Third, to reduce the premiums required by the Plan.
- Fourth, to improve the Plan as provided by the State Treasurer, subject to approval by the Board of Trustees.

Currently there is no provision to use the excess funds to be set aside to reduce unfunded actuarial accrued liability for post-employment retiree health benefits, and the General Assembly, not the State Treasurer, has the authority to use finds to improve the Plan

Section 5 would amend the law [G.S. 135-48.22], pertaining to the powers and duties of the trustees, to include the ability to approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits in the powers delegated to the Board of Trustees.

Section 6 would amend the law [G.S.135-48.30(a)], outlining the powers and duties of the State Treasurer to provide that the State Treasurer the power to set aside funds from the Plan to reduce the Plan's unfunded actuarial accrued liability for post-employment retiree health benefits.

Section 7 would amend the law [G.S. 135-48.20] establishing the Board of Trustees to add a new subsection making individual members of the Board of Trustees immune from civil liability for actions taken in their official capacity except when:

- The member was not acting within the scope of the member's duties.
- The member was not acting in good faith.
- The member committed gross negligence or willful or wonton misconduct.
- The member derived an improper personal financial benefit from a transaction.
- The member incurred liability from the operation of a motor vehicle.

EFFECTIVE DATE: Section 3 would become effective October 1, 2017, and apply to children born to covered employees on or after that date. The remainder of bill would become effective when it becomes law.

** Jason Moran-Bates substantially contributed to this summary.*

HOUSE BILL 299*

Short Title:	State Health Plan Administrative Changes.-AB	(Public)
Sponsors:	Representatives Dobson, Corbin, Clampitt, and Henson (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Insurance, if favorable, State Personnel	

March 13, 2017

A BILL TO BE ENTITLED

AN ACT TO MAKE CLARIFYING AND ADMINISTRATIVE CHANGES TO THE LAWS RELATING TO THE NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-48.44(a) reads as rewritten:

"**§ 135-48.44. Cessation of coverage.**

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

...

(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact regarding eligibility or enrollment information or in a claim for reimbursement of medical services under the Plan. The State Treasurer may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the State Treasurer to make an exception as allowed for under this subdivision.

...."

SECTION 2. G.S. 135-48.40(c)(2) reads as rewritten:

"(2) Employees and members of the General Assembly with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the ~~State.~~State unless prohibited by law. The total premium is the sum of the Plan's total employer premium contribution rate plus the employee or retiree's contribution for individual and dependent coverage."

SECTION 3.(a) G.S. 135-48.42(a) reads as rewritten:

"(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory or other

contributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees ~~having coverage type (2) or (3), as outlined in G.S. 135-48.43(d)~~ shall be ~~automatically~~ covered at the time of birth ~~without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions~~ so long as the ~~claims processor~~ Plan receives notification within 30 days of the date of ~~birth that the employee desires to change from coverage (1) to coverage type (2) or (3), provided that~~ birth and the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born."

SECTION 3.(b) This section becomes effective October 1, 2017, and applies to children born to covered employees on or after that date.

SECTION 4. G.S. 135-48.5(a) reads as rewritten:

"(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used ~~first,~~ in the following order:

(1) First, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented ~~claims, second,~~ claims.

(2) Second, up to fifty percent (50%) of any unencumbered balance remaining after providing for incurred but unpresented claims may be set aside by the State Treasurer, subject to approval by the Board of Trustees, to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits.

(3) Third, to reduce the premiums required in providing the benefits of the health benefits ~~programs, and third~~ programs.

(4) Fourth, to improve the plan, as may be provided by the ~~General Assembly.~~State Treasurer, subject to approval by the Board of Trustees.

The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein. The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 147-69.3."

SECTION 5. G.S. 135-48.22 is amended by adding a new subdivision to read:

"(7) Approve set-asides to reduce the State's unfunded actuarial accrued liability for post-employment retiree health benefits as provided in G.S. 135-48.5(a) and G.S. 135-48.30(a)(18)."

SECTION 6. G.S. 135-48.30(a) is amended by adding a new subdivision to read:

"(18) Set aside funds from the Public Employee Health Benefit Fund to reduce the State unfunded actuarial accrued liability for post-employment retiree health

benefits as provided in G.S. 135-48.5(a), subject to approval by the Board of Trustees."

SECTION 7. G.S. 135-48.20 is amended by adding a new subsection to read:

"(n) Immunity. – Except to the extent provided under Article 31A of Chapter 143 of the General Statutes and to the extent of insurance coverage purchased pursuant to G.S. 58-32-15, a person serving on the Board of Trustees shall be immune individually from civil liability for monetary damages for any act, or failure to act, arising out of that service, except where any of the following apply:

(1) The person was not acting within the scope of that person's official duties.

(2) The person was not acting in good faith.

(3) The person committed gross negligence or willful or wanton misconduct that resulted in damages or injury.

(4) The person derived an improper personal financial benefit, either directly or indirectly, from the transaction.

(5) The person incurred the liability from the operation of a motor vehicle."

SECTION 8. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2017

Legislative Actuarial Note
Health Benefits

BILL NUMBER: House Bill 299 (First Edition)

SHORT TITLE: State Health Plan Administrative Changes.-AB

SPONSOR(S): Representatives Dobson, Corbin, Clampitt, and Henson

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

Section 1: Amends G.S. 135-48.44(a) to allow the Plan to terminate coverage when an individual knowingly and willfully provides false information during the enrollment process. Currently, the Plan can terminate coverage when an individual provides false information related to a claim.

Section 2: Amends G.S. 135-48.40(c)(2) to clarify that the retiree's premium for one-half contributory coverage is half of the employer contribution established by the General Assembly plus the employee contribution.

Section 3: Amends G.S. 135-48.42(a) to require members to enroll newborns they wish to cover within 30 days of birth. Currently, additional children born to a member who has elected employee-child or family coverage are automatically covered.

Sections 4-6: Allow the State Treasurer, subject to approval by the Board of Trustees, to set aside up to 50% of any unencumbered balance to reduce the State's unfunded accrued liability for retiree medical benefits.

Section 7: Provides limited civil immunity to members of the Board of Trustees.

EFFECTIVE DATE: Section 3 becomes effective October 1, 2017 and applies to children born on or after that date. The remainder of the bill is effective when it becomes law.

ESTIMATED IMPACT ON STATE:

The Segal Company, the actuary for the Plan, estimates that the bill will have negligible financial impact on the Plan. However, The Segal Company notes that if funds are set aside under Sections 4-6, then they may need to be reimbursed through higher premium contributions in future years. This is because the funds would most likely be set aside in a trust specifically designed to pay premiums on behalf of retirees, rather than for the broader purpose of paying claims for services to all Plan members.

Hartman & Associates, the actuary for the General Assembly, also estimates that Sections 1-3 and 7 will not have a material impact on the Plan. Hartman & Associates notes that it is likely that any amount set aside under Sections 4-6 would increase the magnitude of future premium increases or benefit reductions, although we do not know the likelihood or amount of any transfers that may be made.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments and charter schools may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

The State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement, with the exception of many Medicare-eligible retirees who are in fully-insured Medicare Advantage plans. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who participate in a plan with a non-zero premium or who elect dependent coverage. Benefit and premium changes are typically effective at January 1. The Plan's PPO benefit design includes three alternative benefit levels listed below:

1) The "Traditional" 70/30 plan that offers higher out-of pocket requirements in return for lower employee and retiree premiums and only one wellness activity,

2) The "Enhanced" 80/20 plan that offers lower out-of-pocket requirements with higher employee and retiree premiums, which can be lowered by completing three wellness activities, and

3) The Consumer-Directed Health Plan (CDHP) that applies deductibles and co-insurance to all services and offers lower employee and retiree premiums if one completes wellness activities

Medicare-eligible retirees are offered three alternative plans:

1) The "Traditional" 70/30 plan as coverage secondary to Medicare for medical services plus a pharmacy benefit plan,

2) "Base" Medicare Advantage Prescription Drug Plan (MA-PDP) from United Healthcare, that is actuarially equivalent to the "Enhanced" 80/20 Plan and applies in-network out-of-pocket requirements at out-of-network providers

3) "Enhanced" MA-PDP, identical to the "Base" MA-PDP, except with lower co-pays and higher retiree premiums

The following tables provide a summary of the most common monthly premium rates for the Plan in 2017:

Active Employees and Non-Medicare Retirees (if Fully Subsidized)

	Employer Share	Employee/Retiree Share	
		Complete All Wellness Activities *	Complete No Wellness Activities
Traditional 70/30 Plan	$479.48	$0.00	$40.00
Enhanced 80/20 Plan	$479.48	$15.04	$105.04
Consumer-Directed Health Plan (85/15)	$479.48	$0.00	$80.00

* Members receive credits for each activity. We have shown all or none for simplicity.

Medicare Retirees (if Fully Subsidized)

Medicare Advantage Plans

	Employer Share	Employee/Retiree Share
MA-PDP Base Plan	$372.56	$0.00
MA-PDP Enhanced Plan	$372.56	$64.00

Alternate Plan

	Employer Share	Employee/Retiree Share
Traditional 70/30 Plan	$372.56	$0.00

Dependents (paid by employee/retiree in addition to premiums above)

	All Dependents are Non-Medicare			One or More Medicare Dependents		
	Traditional 70/30	Enhanced 80/20	CDHP 85/15	MA-PDP Base	MA-PDP Enhanced	Traditional 70/30
Employee/Retiree + Children	$218.14	$290.14	$196.32	$124.80	$188.80	$155.20
Employee/Retiree + Spouse	$562.10	$668.48	$505.90	$124.80	$188.80	$408.08
Employee/Retiree + Family	$598.70	$708.72	$538.82	$249.60	$377.60	$444.66

The employer share of premiums for retirees is paid from the Retiree Health Benefit Fund. During FY 2016-17, employers contribute 5.81% of active employee payroll into the Fund. Total contributions for the year are projected to be approximately $950 million.

Financial Condition

Projected Results for CY 2017 and CY 2018 – The following summarizes projected financial results for 2017 and 2018, based on financial experience through September 2016. The projection assumes a 7.0% annual claims growth trend for medical claims, an 8.5% trend for pharmacy claims, benefit provisions and member-paid premiums as currently adopted by the Board, and 3.5% premium increases in 2018.

	($ millions) Projected CY 2017	Projected CY 2018
Beginning Cash Balance	$945.7	$834.1
Receipts:		
Net Premium Collections	$3,264.8	$3,369.6
Medicare Subsidies	$16.5	$16.6
Investment Earnings	$7.2	$6.2
Total	$3,288.5	$3,392.4
Disbursements:		
Net Medical Claim Payment Expenses	$2,271.9	$2,374.3
Net Pharmacy Claim Payment Expenses	$706.9	$787.2
Medicare Advantage Premiums	$192.6	$255.4
Administration and Claims-Processing Expenses	$228.7	$219.6
Total	$3,400.1	$3,636.5
Net Operating Income (Loss)	($111.6)	($244.1)

Of the premiums paid in CY 2017, an estimated $2.1 billion is derived from General Fund sources and an estimated $0.1 billion is derived from Highway Fund sources.

Other Information

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, fraud detection, and other authorized actions by the State Treasurer, Executive Administrator, and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Medical claim costs are expected to increase at a rate of 7.0% annually and pharmacy claim costs are expected to increase at a rate of 8.5% annually according to assumptions adopted by the Board of Trustees. The active population is projected to decline by 1% per year and the retired population is projected to increase by 1% per year.

Enrollment as of January 1, 2017

I. No. of Participants	Traditional 70/30	Enhanced 80/20	Consumer Directed	Medicare Advantage	Total	Percent of Total
Actives						
Employees	125,378	163,187	21,119	-	309,684	43.3%
Dependents	75,032	73,137	21,903	-	170,072	23.8%
Sub-total	200,410	236,324	43,022	-	479,756	67.1%
Retired						
Employees	59,349	25,367	1,671	111,890	198,277	27.7%
Dependents	8,029	4,182	903	9,447	22,561	3.2%
Sub-total	67,378	29,549	2,574	121,337	220,838	30.9%
Other						
Employees	2,618	5,921	980	-	9,519	1.3%
Dependents	1,522	2,368	767	-	4,657	0.7%
Sub-total	4,140	8,289	1,747	-	14,176	2.0%
Total						
Employees	187,345	194,475	23,770	111,890	517,480	72.4%
Dependents	84,583	79,687	23,573	9,447	197,290	27.6%
Grand Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**	**100%**
Percent of Total	**38.0%**	**38.4%**	**6.6%**	**17.0%**	**100.0%**	

II. Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	144,962	154,308	12,663	102,443	414,376
Employee Child(ren)	25,805	26,363	5,739	179	58,086
Employee Spouse	6,105	5,106	1,533	9,268	22,012
Employee Family	10,473	8,698	3,835		23,006
Total	**187,345**	**194,475**	**23,770**	**111,890**	**517,480**

Percent Enrollment by Contract	Traditional	Enhanced	CDHP	MA	Total
Employee Only	77.4%	79.3%	53.3%	91.6%	80.1%
Employee Child(ren)	13.8%	13.6%	24.1%	0.2%	11.2%
Employee Spouse	3.3%	2.6%	6.4%	8.3%	4.3%
Employee Family	5.6%	4.5%	16.1%	0.0%	4.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

III. Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	159,441	178,330	26,685	80,445	444,901
Male	112,487	95,832	20,658	40,892	269,869
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Sex	Traditional	Enhanced	CDHP	MA	Total
Female	58.6%	65.0%	56.4%	66.3%	62.2%
Male	41.4%	35.0%	43.6%	33.7%	37.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	73,899	70,290	18,777	3	162,969
26 to 45	68,332	76,095	13,837	228	158,492
46 to 55	46,137	56,424	8,217	873	111,651
56 to 65	47,542	66,377	6,204	11,420	131,543
66 & Over	36,018	4,976	308	108,813	150,115
Total	**271,928**	**274,162**	**47,343**	**121,337**	**714,770**

Percent Enrollment by Age	Traditional	Enhanced	CDHP	MA	Total
25 & Under	27.2%	25.6%	39.7%	0.0%	22.8%
26 to 45	25.1%	27.8%	29.2%	0.2%	22.2%
46 to 55	17.0%	20.6%	17.4%	0.7%	15.6%
56 to 65	17.5%	24.2%	13.1%	9.4%	18.4%
66 & Over	13.2%	1.8%	0.7%	89.7%	21.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	48,342	11,835	60,177
Medicare Eligible in Traditional 70/30	38,045	1,279	39,324
Medicare Eligible in Base Medicare Advantage Plans	93,707	6,871	100,578
Medicare Eligible in Enhanced Medicare Advantage Plans	18,183	2,576	20,759
Total	**198,277**	**22,561**	**220,838**

Percent Enrollment by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	24.4%	52.5%	27.2%
Medicare Eligible in Traditional 70/30	19.2%	5.7%	17.8%
Medicare Eligible in Base Medicare Advantage Plans	47.3%	30.5%	45.5%
Medicare Eligible in Enhanced Medicare Advantage Plans	9.2%	11.4%	9.4%
Total	**100.0%**	**100.0%**	**100.0%**

VI. Enrollment By Major Employer Groups	Employees	Dependents	Total
State Agencies	68,024	32,792	100,816
UNC System	52,910	34,217	87,127
Local Public Schools	168,892	91,264	260,156
Charter Schools (88 entities)	4,111	2,688	6,799
Local Community Colleges	15,747	9,111	24,858
Other			
Local Goverments (91 entities)	8,882	4,128	13,010
COBRA	637	529	1,166
Sub-total	319,203	174,729	493,932
Retirement System *	198,277	22,561	220,838
Total	**517,480**	**197,290**	**714,770**

Percent Enrollment by Major Employer Groups	Employees	Dependents	Total
State Agencies	13.1%	16.6%	14.1%
UNC System	10.2%	17.3%	12.2%
Local Public Schools	32.6%	46.3%	36.4%
Charter Schools	0.8%	1.4%	1.0%
Local Community Colleges	3.0%	4.6%	3.5%
Other			
Local Goverments	1.7%	2.1%	1.8%
COBRA	0.1%	0.3%	0.2%
Sub-total	61.7%	88.6%	69.1%
Retirement System	38.3%	11.4%	30.9%
Total	**100.0%**	**100.0%**	**100.0%**

* Includes 6 employees and 6 dependents covered as firefighters, rescue squad workers, or National Guard members

SOURCES OF DATA:

The Segal Company; baseline financial projections updated through Q3 CY2016 with 3.52% employer and employee premium increase in 2018, no further increases in wellness premiums/credits; dated January 24, 2017. Filename "CY16 Q3 - New Baseline - S1 - No Credit Increase in 2018+.pdf"

-Actuarial Note, Hartman & Associates, "House Bill 299/Senate Bill 218: An Act Make Clarifying and Administrative Changes to the Laws Relating to the State Health Plan for Teachers and State Employees", March 14, 2017, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, The Segal Company, House Bill 299, "State Health Plan Administrative Changes-AB", March 27, 2017, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: David Vanderweide

APPROVED BY:

Mark Trogdon, Director
Fiscal Research Division

DATE: April 10, 2017

Signed Copy Located in the NCGA Principal Clerk's Offices

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 299*

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

H299-ASH-14 [v.2]

Amends Title [NO]
First Edition

Date _____,2017

Senator Krawiec

moves to amend the bill on page 3, line 16, by rewriting the line to read:

"**SECTION 8.** G.S. 135-48.1 reads as rewritten:

"**§ 135-48.1. General definitions.**

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

(1) Authorized representatives who are assisting the State Health Plan Division staff. – Staff of the Department of the State Treasurer, staff of the Department of Justice, or persons providing internal auditing assistance required under G.S. 143-746(b).

(1a) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

...."

SECTION 9. Part 1 of Article 3B of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-48.16. Fraud detection and audit programs.**

(a) Access to Persons and Records. – In the course of conducting an investigation or a audit under G.S. 135-48.30(a)(9), the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall have ready access to the following:

(1) Persons, books, records, reports, vouchers, correspondence, files, personnel files, investments, and any other documentation of any employing unit. The Plan shall have the authority to both examine and make copies of the information described in this subdivision. The review of State tax returns shall be limited to matters of official business, and the Plan's report shall not violate the confidentiality provisions of the tax laws.

(2) Persons, records, papers, reports, vouchers, correspondence, books, and any other documentation that is in the possession of any individual, private corporation, institution, association, board, or other organization that pertain to any benefits received, disbursed, or otherwise handled pursuant to a grant or contract from the federal government, the State, or its political subdivisions. Providers of social and medical services to a beneficiary shall

make copies of records they maintain for services provided to the beneficiary.

(b) Records of Providers of Social and Medical Services. – Providers of social and medical services who provide ready access to the Plan under subdivision (2) of subsection (a) of this section shall make copies of records they maintain for services provided to a beneficiary available to the Plan or to the authorized representatives who are assisting the State Health Plan Division staff. The Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall request records in writing by providing the name of each beneficiary from whom records are sought, the purpose of the request, the authority for the request, and a reasonable period of time for the production of record copies by the provider. A provider may charge, and the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall, in accordance with G.S. 90-411, pay a reasonable fee to the provider for copies of the records provided.

(c) Fraud Detection and Audit Reports and Work Papers. – The Plan shall maintain for 10 years a complete file of all compliance investigative reports, fraud investigative reports, and reports of other examinations, investigations, surveys, and reviews issued under the Plan's authority under G.S. 135-48.30(a)(9). Fraud or compliance investigation work papers and other evidence or related supportive material directly pertaining to the work of the State Health Plan Division of the Department of State Treasurer shall be retained according to an agreement between the Plan and State Archives. To promote intergovernmental cooperation and avoid unnecessary duplication of fraud investigative effort, and notwithstanding local unit personnel policies to the contrary, pertinent work papers and other supportive material relating to issued fraud or compliance investigation reports may be, at the discretion of the Executive Administrator of the Plan, and unless otherwise prohibited by law, made available for inspection by duly authorized representatives of the State and federal government who desire access to, and inspection of, such records in connection with some matter officially before them, including criminal investigations. Except as provided in this section, or upon an order issued in Wake County Superior Court upon 10 days' notice and hearing finding that access is necessary to a proper administration of justice, fraud investigation work papers and related supportive material shall be kept confidential, including any information developed as a part of the investigation."

SECTION 10.(a) G.S. 105-259(b) is amended by adding a new subdivision to read:

"(39a) To furnish to the Department of State Treasurer periodically upon request the State tax return of a beneficiary, or the wage and income statement of a beneficiary, or the NC-3 information of an employer for the purpose of assisting a fraud or compliance investigation or audit under G.S. 135-48.30(a)(9); or in accordance with G.S. 135-48.16; provided, however, that no federal tax information may be disclosed under this subpart unless such a disclosure is permitted by section 6103 of the Code."

SECTION 10.(b) The Department of Revenue and the Department of the State Treasurer shall within a reasonable time following the effective date of this legislation, but not later than June 30, 2018, enter into a confidential information sharing agreement settling data transfer protocols, required security measures, audit mechanisms, and the like, so that the two

departments can thereafter develop and implement the information exchange authorized by this act.

SECTION 11. G.S. 135-48.41 is amended by adding a new subsection to read:

"(k) If a retiree is a prisoner serving an active sentence in the State prison system and covered under G.S. 148-19, then the incarcerated retiree shall not, during the time of incarceration, be eligible for retiree coverage under G.S. 135-48.40(a)(1), G.S. 135-48.40(b)(3), G.S. 135-48.40(c)(2), or G.S. 135-48.40(d)(11)."

SECTION 12. This act is effective when it becomes law."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 478:
Required Experience for MH/DD/SAS QPs.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 18, 2017
Introduced by:	Reps. Dobson, S. Martin, K. Hall, Brisson	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	Second Edition		

OVERVIEW: House Bill 478 would require the Department of Health and Human Services (DHHS) to amend the qualifications for Qualified Professionals in the mental health, developmental disabilities, and substance abuse services (MH/DD/SAS) system of care to count all years of full-time MH/DD/SAS experience toward the required number of years' experience, regardless of when the experience was obtained.

CURRENT LAW: Administrative rule 10A N.C.A.C. 27G .0104 and the Medicaid State Plan state the qualifications for Qualified Professionals within the MH/DD/SAS system of care. Currently, Qualified Professionals must have either one, two, or four years of full-time MH/DD/SAS experience after completing educational requirements. The number of years of MH/DD/SAS experience required depends on the whether the level of education attained is a master's degree or a bachelor's degree and whether the degree is in a human services field.

BILL ANALYSIS:

House Bill 478 would direct DHHS to amend the qualifications for Qualified Professionals that are established in rule, Medicaid clinical coverage policy, and in the Medicaid State Plan, to count all years of full-time MH/DD/SAS experience toward the number of years of MH/DD/SAS experience required based on the type of degree held and the field of study, regardless of whether the experience was obtained before or after completion of the degree. DHHS would be required to submit any necessary State Plan amendments to the Centers for Medicare and Medicaid Services (CMS) by October 1, 2017.

EFFECTIVE DATE: The bill would be effective when it becomes law, and the required changes to the qualifications for Qualified Professions would not be effective until CMS approves the necessary Medicaid State Plan amendments.

Staff attorney Jennifer Hillman contributed substantially to the preparation of this summary.

Karen Cochrane-Brown
Director

H478-SMTY-56 E2 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H 2

HOUSE BILL 478
Committee Substitute Favorable 4/5/17

Short Title: Required Experience for MH/DD/SAS QPs. (Public)

Sponsors:

Referred to:

March 27, 2017

A BILL TO BE ENTITLED

AN ACT TO ALLOW ALL YEARS OF FULL-TIME MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE SERVICES (MH/DD/SAS) EXPERIENCE TO APPLY TO THE QUALIFICATIONS REQUIRED FOR MH/DD/SAS QUALIFIED PROFESSIONALS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services (DHHS) shall amend the qualifications for Qualified Professionals within the mental health, developmental disability, and substance abuse services (MH/DD/SAS) system of care, as defined in rule, clinical care policies for the Medicaid program, and the North Carolina Medicaid State Plan. Qualifications for Qualified Professionals shall allow for all years of full-time MH/DD/SAS experience to qualify as years of experience, rather than limiting qualifying full-time MH/DD/SAS experience to only that experience which is obtained post-bachelor's degree or post-graduate degree. No later than October 1, 2017, any State Plan amendment necessary to effect these changes shall be submitted by DHHS to the Centers for Medicare and Medicaid Services (CMS).

SECTION 2. Any changes to clinical coverage policies and any changes to rules adopted by the Department of Health and Human Services relating to the qualifications for Qualified Professionals required under Section 1 of this act shall not become effective until DHHS has received CMS approval of the State Plan amendment required by Section 1 of this act.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 478

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

H478-ATY-26 [v.4]

Amends Title [NO]
Second Edition

Date 5/18/17 ,2017

Senator KRAWIEC

moves to amend the bill on page 1, line 7 by rewriting the line to read:

"**SECTION 1.** The Department of Health and Human Services (DHHS) and its Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall amend";

and on page 1, lines 11-14 by rewriting the lines to read:

"The amendments to the qualifications for Qualified Professionals shall ensure that the years of full time MH/DD/SAS experience required by the rule may be obtained either before or after obtaining the required educational degree. No later than December 1, 2017, any State Plan amendment necessary to";

and on page 1, line 16 by rewriting the line to read:

"Services (CMS). The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall amend the rules as soon as possible, but no later than six months after the date that DHHS has received CMS approval of the necessary Medicaid State Plan amendments.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 657:
Improve Adult Care Home Regulation.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 17, 2017
Introduced by:	Reps. Burr, Dobson, White, Sauls	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	Second Edition		

OVERVIEW: House Bill 657 makes the following changes pertaining to adult care homes: exempts from certificate of need review the acquisition of certain unlicensed adult care homes; implements an informal dispute resolution process for certain inspection findings; changes the training requirements for personal care aides; makes changes to the star rating program; and requires the Department of Health and Human Services to study the Star Rated Certificate Program and report on progress to the Joint Legislative Oversight Committee on Health and Human Services by February 1, 2018, with a final report by October 1, 2018.

CURRENT LAW:

Adult Care Home – Defined in G.S. 131D-2.1(3) as an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide supervision to persons with cognitive impairments. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

G.S. 131E-184 – Allows the Department of Health and Human Services to exempt from certificate of need review a new institutional health service if notice is received that certain specified conditions exist.

BILL ANALYSIS: **Section 1** of HB 657 would amend G.S. 131D-2.4 which pertains to the licensure of adult care homes. *Subsection (a)* would be amended to provide that a facility not currently licensed as an adult care home but licensed as such in the preceding 12 months, is considered and existing health service facility under G.S. 131E-184(a)(8).

Subsection (c) of G.S. 131D-2.4 outlines the circumstances in which new licenses are prohibited from being issued to applicants. This subsection would be amended by the bill to incorporate circumstances in which the owner, principal, or affiliate of a licensable facility was also responsible for the operation and had its license revoked; summarily suspended; was assessed a penalty for a Type A or B violation; had its license downgraded to provisional status or admissions suspended; or where fees, fines, and penalties imposed by the State against the facility have not been paid. The changes also contemplate situations where the owner, principal, or affiliate is not responsible for operation in an effort to avoid emergency resident relocation. The prohibition period on new licenses is increased in certain circumstances where the owner, principal or affiliate was also responsible for operation. A new subdivision (5) is added to prohibit a new license from being issued when the owner, principal, or affiliate is also responsible for the operation of the facility and outstanding fees, fines and penalties have not been paid.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Subsection (f) is amended to provide that the consent of the current licensee is not a required prerequisite to a change of ownership if the current licensee has been: (i) removed from the facility due to summary ejectment or due to the expedited eviction of drug traffickers and other criminals, or (ii) abandoned the facility, as determined by the reasonable discretion of the Department of Health and Human Services (DHHS).

Subsection (g) is a new subsection that provides that any applicant for licensure who wishes to contest the denial of a license is entitled to an administrative hearing as provided in Chapter 150B (Administrative Procedure). The applicant must file a petition for a contested case within 30 days after the date DHHS mails the written notice of denial to the applicant.

Section 2 would amend G.S. 131D-2.11 pertaining to inspections, monitoring, and review by the State and by county departments of social services. The section is amended to set out an "Informal Dispute Resolution – Division of Health Service Regulation" process (subsection (a2) of the current law) and an "Informal Dispute Resolution – County Departments of Social Services" process (new subsection (a3). The new "Informal Dispute Resolution – County Departments of Social Services" process provides the following:

(1) The Division of Health Service Regulation (DHSR) and county department of social services (DSS) must jointly offer each adult care home an opportunity, at the facility's request and upon the facility's receipt of the official statement of deficiencies, to informally resolve disputed findings from inspections conducted by the county DSS that resulted in the citation of a Type A1 violation, Type A2 violation, Uncorrected Type A1, violation, Uncorrected Type A2 violation, or Uncorrected Type B violation, in accordance with the section.

(2) Provides that failure of the DHSR and county DSS to complete informal dispute resolution timely does not delay the effective date of any enforcement action taken by the DHSR against an adult care home.

(3) Provides that an adult care home is not entitled to seek a delay of any enforcement action against it on the grounds that the DHSR and the county DSS has not completed informal dispute resolution prior to the effective date of the enforcement action.

(4) Provides that if an adult care home successfully demonstrates during the informal dispute resolution process that any of the deficiencies cited in the official statement of deficiencies should not have been cited, the county DSS shall remove the incorrectly cited deficiencies from the official statement of deficiencies and the DHSR must rescind any enforcement actions imposed on the adult care home solely as a result of the incorrectly cited deficiencies.

(5) Requires the DHSR to make available on its Internet Web site the informal dispute resolution procedures for adult care homes.

Section 3 of the bill would amend G.S. 131D-4.3 which outlines the minimum rules that must be adopted for adult care homes by the NC Medical Care Commission. Specifically the rules pertaining to personal care aides are being amended to provide that the minimum amount of training is 80 hours regardless of whether the individual is employed in an adult care home or a family care home. (Currently, 75 hours is required for aides performing heavy care tasks and a minimum of 40 hours of training is required for all personal care aides. Also under current law, 20 of the 40 hours of training are required to be classroom training, and family care home aides that do not have heavy care residents are limited to a minimum of 20 hours of training.) The facility is allowed to exempt from the 80-hour training requirement any personal care aides who are or have been either licensed as a health care professional or listed on the Nurse Aide Registry.

Section 4 would require the DHSR and county DSSs to establish procedures to implement the requirement of the Informal Dispute Resolution – County Departments of Social Services (G.S. 131D-2.11(a3)), contained in Section 2 of the act, 60 days after the effective date of the act (October 1, 2017). Section 4 of the bill is effective when it becomes law.

Section 5 would amend G.S. 131D-10 which provides for the adult care home rated certificates. *Subsection (b)* of G.S. 131D-10 would be amended to provide that the DHSR must issue ratings to a facility pursuant to rules adopted by the NC Medical Care Commission based on both:

(1) Inspections and investigations of complaints conducted pursuant to G.S. 131D-2.11 [Inspections, monitoring and review by the State and county DSSs] and G.S. 131D-26 [Enforcement and investigation] that revealed noncompliance with the statutes and rules.

(2) The facilities participation in any quality improvement programs approved by the Department.

Subsection (c) of G.S. 131D-10 that currently requires Type A penalties to affect the rating for 24 months and Type B penalties to affect the rating for 12 months is being removed.

A new subsection (c1) would be added to require DHSR to issue a star rating to a facility within 45 days from the date the Division mails the survey or inspection report to the facility, except when a request for an informal dispute resolution is made. If a facility makes a timely request for an informal dispute resolution, the DHSR must issue a star rating to the facility within 15 days from the date the Division mails the decision to the facility.

Subsection (d) would amend the availability of the rating information to require each facility rating and specific information regarding the basis for calculating each facility rating to be available free of charge on the DHSR Web site.

Section 6 of the bill would require DHHS to conduct a study of the North Carolina Star Rated Certificate Program. The study must (i) evaluate the effectiveness of the program in providing information to consumers of adult care home services, (ii) examine potential evidence-based alternatives, and (iii) make recommendations for any regulatory or legislative changes that could result in improvement of the current system. By February 1, 2018, the Department is required to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the progress of the study. By October 1, 2018, the Department must conclude the study and report its findings and recommendations, including any recommendations for regulatory or legislative changes, to the Oversight Committee and the Fiscal Research Division. Section 6 becomes effective when the bill becomes law.

Section 7 would amend G.S. 131E-184(a)(8) pertaining to the exemption from certificate of need to provide that a facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for purposes of the subdivision when acquiring an existing health service facility, including equipment owned by the health service facility at the time of acquisition. (This conforms to the changes in Section 1 of the bill in G.S. 131D-2.4(a).) Section 7 becomes effective when the bill becomes law.

EFFECTIVE DATE: Except as otherwise provided, the bill would become effective October 1, 2017.

HOUSE BILL 657
Committee Substitute Favorable 4/20/17

Short Title: Improve Adult Care Home Regulation. (Public)

Sponsors:

Referred to:

April 11, 2017

A BILL TO BE ENTITLED

AN ACT MODIFYING THE LAWS PROHIBITING ISSUANCE OF ADULT CARE HOME LICENSES DUE TO PRIOR VIOLATIONS; EXEMPTING FROM CERTIFICATE OF NEED REVIEW NEW INSTITUTIONAL HEALTH SERVICES INVOLVING THE ACQUISITION OF AN UNLICENSED ADULT CARE HOME THAT WAS PREVIOUSLY LICENSED; ESTABLISHING A PROCESS FOR ADULT CARE HOMES TO REQUEST INFORMAL DISPUTE RESOLUTION OF CERTAIN ADVERSE INSPECTION FINDINGS BY COUNTY DEPARTMENTS OF SOCIAL SERVICES PRIOR TO IMPOSITION OF A PENALTY OR ISSUANCE OF A STAR RATING CERTIFICATE BASED ON THE ADVERSE INSPECTION FINDINGS; AMENDING THE RULES PERTAINING TO MINIMUM TRAINING FOR PERSONAL CARE AIDES; ELIMINATING THE TWELVE- TO TWENTY-FOUR-MONTH PENALTY ON ADULT CARE HOME STAR RATINGS; AND DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY THE EFFECTIVENESS OF THE NORTH CAROLINA STAR-RATED CERTIFICATE PROGRAM FOR ADULT CARE HOMES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.4 reads as rewritten:

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of G.S. 131E-184(a)(8).

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure ~~who:~~under any of the following circumstances for the period of time indicated:

(1) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes and was responsible for the operation of the facility that had its license revoked until ~~one full year~~ five years after the date ~~of revocation;~~the revocation became effective.

(1a) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes and was responsible for the operation of the facility that had its license summarily suspended until five years after the date the suspension was lifted or terminated.

(2) Is the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the ~~Department;~~Department.

(3) Is the owner, principal, or affiliate of an adult care home and is responsible for the operation of the facility that had its license ~~summarily suspended or~~ downgraded to provisional status or had its admissions suspended as a result of ~~Type A or Type B~~ violations under this Article, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes until six months from the date of ~~reinstatement of the license,~~ restoration from provisional to full licensure, ~~or~~ termination of the provisional license, ~~as applicable;~~ or lifting or termination of the suspension of admissions, as applicable.

~~(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under this Article or Chapter 122C of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.~~

(5) Is or was the owner, principal, or affilate of an adult care home and is responsible for the operation of the facility where outstanding fees, fines, and penalties imposed by the State against the facility have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration under this subdivision.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of renewal unless revoked earlier by the Secretary for failure to comply with any part of this section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall not renew a license if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal

application shall contain all necessary and reasonable information that the Department may require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

(f) The Department shall not issue a new license for a change of ownership of an adult care home if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The consent of the current licensee is not a required prerequisite to a change of ownership of an adult care home if the current licensee has (i) been removed from the facility pursuant to Articles 3 and 7 of Chapter 42 of the General Statutes or (ii) abandoned the facility, as determined by the Department's reasonable discretion.

(g) Any applicant for licensure who wishes to contest the denial of a license is entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. The applicant shall file a petition for a contested case within 30 days after the date the Department mails a written notice of the denial to the applicant."

SECTION 2. G.S. 131D-2.11 reads as rewritten:

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

...

(a2) Informal Dispute ~~Resolution.~~Resolution – Division of Health Service Regulation. –

(1) The Division of Health Service Regulation shall offer each adult care home an opportunity, at the facility's request and upon the facility's receipt of the official statement of deficiencies, to informally resolve disputed findings from inspections conducted by the Division of Health Service Regulation in accordance with this section.

(2) Failure of the Division of Health Service Regulation to complete informal dispute resolution timely does not delay the effective date of any enforcement action taken by the Division of Health Service Regulation against an adult care home.

(3) An adult care home is not entitled to seek a delay of any enforcement action against it on the grounds that the Division of Health Service Regulation has not completed informal dispute resolution prior to the effective date of the enforcement action.

(4) If an adult care home successfully demonstrates during informal dispute resolution that any of the deficiencies cited in the official statement of deficiencies should not have been cited, the Division of Health Service Regulation shall remove the incorrectly cited deficiencies from the official statement of deficiencies and rescind any enforcement actions imposed on the adult care home solely as a result of the incorrectly cited deficiencies.

(5) ~~Upon request, the~~The Division of Health Service Regulation shall ~~provide an adult care home with written notification of these informal dispute resolution procedures.~~make available on its Internet Web site the informal dispute resolution procedures for adult care homes.

(a3) Informal Dispute Resolution – County Departments of Social Services. –

(1) The Division of Health Service Regulation and county department of social services shall jointly offer each adult care home an opportunity, at the facility's request and upon the facility's receipt of the official statement of deficiencies, to informally resolve disputed findings from inspections conducted by the county department of social services that resulted in the citation of a Type A1 violation, Type A2 violation, Uncorrected Type A1,

violation, Uncorrected Type A2 violation, or Uncorrected Type B violation, in accordance with this section.

(2) Failure of the Division of Health Service Regulation and county department of social services to complete informal dispute resolution timely does not delay the effective date of any enforcement action taken by the Division of Health Service Regulation against an adult care home.

(3) An adult care home is not entitled to seek a delay of any enforcement action against it on the grounds that the Division of Health Service Regulation and the county department of social services has not completed informal dispute resolution prior to the effective date of the enforcement action.

(4) If an adult care home successfully demonstrates during informal dispute resolution that any of the deficiencies cited in the official statement of deficiencies should not have been cited, the county department of social services shall remove the incorrectly cited deficiencies from the official statement of deficiencies and the Division of Health Service Regulation shall rescind any enforcement actions imposed on the adult care home solely as a result of the incorrectly cited deficiencies.

(5) The Division of Health Service Regulation shall make available on its Internet Web site the informal dispute resolution procedures for adult care homes.

...."

SECTION 3. G.S. 131D-4.3(a) reads as rewritten:

"(a) Pursuant to G.S. 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure at a minimum, but shall not be limited to, the provision of each of the following by adult care homes:

(1) Repealed by Session Laws 2000-111, s. 1.

(2) A minimum of ~~75~~ 80 hours of training for personal care ~~aides performing heavy care tasks and a minimum of 40 hours of training for all personal care~~ aides. The training for aides ~~providing heavy care tasks~~ shall be comparable to State-approved Certified Nurse Aide I training. ~~For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum:~~

~~a. Basic nursing skills;~~

~~b. Personal care skills;~~

~~c. Cognitive, behavioral, and social care;~~

~~d. Basic restorative services;~~

~~e. Residents' rights.~~

~~A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements of this subdivision;~~ The facility may exempt from the 80-hour training requirement any personal care aides who are or have been either licensed as a health care professional or listed on the Nurse Aide Registry.

(3) Monitoring and supervision of ~~residents;~~residents.

(4) Oversight and quality of care as stated in ~~G.S. 131D-4.1; and~~G.S. 131D-4.1.

(5) Adult care homes shall comply with all of the following staffing requirements:

a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per

each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater;

b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater;

c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census).

~~In addition to these requirements, the~~ The facility shall provide staff to meet the needs of the facility's ~~heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this subdivision, the term "heavy care resident" means an individual residing in an adult care home who is defined "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs.~~ residents. Each facility shall post in a conspicuous place information about required staffing that enables residents and their families to ascertain each day the number of direct care staff and supervisors that are required by law to be on duty for each shift for that day."

SECTION 4.(a) The Division of Health Service Regulation and county departments of social services shall establish procedures to implement the requirements of G.S. 131D-2.11(a3), as amended by this act, within 60 days after the effective date of this act.

SECTION 4.(b) This section is effective when it becomes law.

SECTION 5. G.S. 131D-10 reads as rewritten:

"**§ 131D-10. Adult care home rated certificates.**

(a) Rules adopted by the North Carolina Medical Care Commission for issuance of certificates to adult care homes shall contain a rating based, at a minimum, on the following:

(1) Inspections and substantiated complaint investigations conducted by the Department to determine compliance with licensing statutes and rules. Specific areas to be reviewed include:

a. Admission and discharge procedures.

b. Medication management.

c. Physical plant.

d. Resident care and services, including food services, resident activities programs, and safety measures.

e. Residents' rights.

f. Sanitation grade.

g. Special Care Units.

h. Use of physical restraints and alternatives.

(b) ~~The initial ratings awarded~~The Division of Health Service Regulation shall issue ratings to a facility pursuant to the rules adopted under this section ~~shall be~~ based on ~~inspections, penalties imposed,~~both of the following:

(1) Inspections and investigations of ~~substantiated~~ complaints conducted pursuant to G.S. 131D-2.11 and G.S. 131D-26 that revealed noncompliance with statutes and ~~rules, that occurred on or after the act becomes law.~~rules.

(2) The facility's participation in any quality improvement programs approved by the Department.

~~(c) Type A penalties shall affect the rating for 24 months from the date the penalty is assessed. Type B penalties shall affect the rating for 12 months from the date the penalty is assessed.~~

(c1) The Division of Health Service Regulation shall issue a star rating to a facility within 45 days from the date the Division mails the survey or inspection report to the facility, except when a timely request has been made by the facility under G.S. 131D-2.11 for informal

dispute resolution. If a facility makes a timely request for informal dispute resolution, the Division of Health Service Regulation shall issue a star rating to the facility within 15 days from the date the Division mails the informal dispute decision to the facility.

(d) Adult care homes shall display the rating certificate in a location visible to the public. Certificates shall include the Web site address for the Department of Health and Human Services, Division of Health Service Regulation, which can be accessed for specific information regarding the basis of the facility rating. For access by the public on request, adult care homes shall also maintain on-site a copy of information provided by the Department of Health and Human Services, Division of Health Service Regulation, regarding the basis of the facility rating. ~~In addition to information on the basis of the rating, the Department of Health and Human Services, Division of Health Service Regulation, shall make information available via its Web site and in the materials available on-site at the facility regarding quality improvement efforts undertaken by the facility including:~~

~~(1) Participation in any quality improvement programs approved by the Department.~~

~~(2) The facility's attainment of the North Carolina New Organizational Vision Award special licensure designation authorized in Article 5, Chapter 131E of the General Statutes.~~

(e) The Department shall make available free of charge to the general public on the Division of Health Service Regulation Web site each facility rating and specific information regarding the basis for calculating each facility rating."

SECTION 6.(a) The Department of Health and Human Services shall conduct a study of the North Carolina Star Rated Certificate Program. The study shall (i) evaluate the effectiveness of the program in providing information to consumers of adult care home services, (ii) examine potential evidence-based alternatives, and (iii) make recommendations for any regulatory or legislative changes that could result in improvement of the current system.

SECTION 6.(b) By February 1, 2018, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the progress of the study. By October 1, 2018, the Department shall conclude the study and report its findings and recommendations, including any recommendations for regulatory or legislative changes, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

SECTION 6.(c) This section is effective when it becomes law.

SECTION 7.(a) G.S. 131E-184(a)(8) reads as rewritten:

"(8) To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of this subdivision."

SECTION 7.(b) This section is effective when it becomes law.

SECTION 8. Except as otherwise provided, this act becomes effective October 1, 2017.

HOUSE BILL 208

Short Title:	Occup. Therapy/Choice of Provider.	(Public)
Sponsors:	Representatives Blackwell, Murphy, Setzer, and Hurley (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Insurance	

March 1, 2017

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT PATIENTS HAVE THE RIGHT TO CHOOSE THEIR OCCUPATIONAL THERAPIST UNDER THEIR HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-50-30(b) is amended by adding a new subdivision to read:

"**§ 58-50-30. Right to choose services of certain providers.**

...

(b) This section applies to the following provider types:

...

(16) An occupational therapist licensed by the North Carolina Board of Occupational Therapy pursuant to Article 18D of Chapter 90 of the General Statutes."

SECTION 2. This act becomes effective October 1, 2017, and applies to health benefit contracts issued, renewed, or amended on or after that date.

Senate Committee On Health Care

May 18, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Debbie Ragan	NCBPTE
JOHN SILVERSTEIN	"
Kathy Arney	NCBPTE
Nicky Boland	NCPTA
Tony Adams	Adams and Assoc.
KAROLYN BREWER	NCALA
Jessica Jenkins	NCDPI
Samantha Bauer	NCDPI
George Robinson	DOI
Meghan Cook	DOI
	CSS
Kari Barsness	Gateway
Sahib Singh	intern Rep. White
Laura Zipersky	Senator Tillman
	Parker Poe Law
JERRY COHEN	NM

Senate Committee On Health Care

May 18, 2017 – Room 643 LOB – 10:00 AM

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Joyce Peters	[illegible]
Lexi Arthur	NCRMA
Elizabeth Robinson	NCRMA
[illegible]	CGA
[illegible]	NCOC
[illegible]	[illegible]
Ken Melton	KMH
Jal Maynard	GPM & ASSOC
Betsy McCorkle	KGANC
Scott Laster	" "
Ryan Blackburn	Con Health
JJ Burpee	NP
Daniel Vanliere	Vidant Health
JJ Darby	Johnson & Johnson
Sue Ann Forrest	NCMS
Rob [illegible]	RLA
[illegible]	NCMS
[illegible]	[illegible]

Senate Committee On Health Care

May 18, 2017 – Room 643 LOB – 10:00 AM

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Donna B Clark	
Mike Murphy	Biogen
Ann Rodriguez	NC Council of Comm Programs
Sarah Wolfe	MWC
Ben Popkin	DHHS
Jesse Goodmon	DHHS/DHSR
Adrian Dellinger	NCDoJ / Counsel for DHHS
Libby Kinsey	DHHS / DHSR
Megan Lamphere	DHHS/DHSR
Kelly Kingston	BP
Phoebe Landon	MWC
Sally Williford	AOC
Flint Benson	SEANC
Hugh Overton	NCHC
Starnes	OST
Watts	OST
Mona Moon	DST/SHP
Lotta Crabtree	DST/SHP

Senate Committee On Health Care

May 18, 2017 – Room 643 LOB – 10:00 AM

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Julia Adams Scheurich	Oak City GR
[illegible]	[illegible]
John McMillan	MFS
John Hardin	MFS
DAVID KOLBACKER	NC Board of Nursing
Robb Jansen	DPI/SBE
[illegible]	GSK
R Rogers	NCLGBA

Senate Committee On Health Care

May 18, 2017 – Room 643 LOB – 10:00 AM

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NAME	FIRM OR AGENCY
[illegible]	NMRS
Rhacgan Jackson	Focus Carolina
John Palumbo	NCHH

Senate Committee on Health Care
Thursday, May 24, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on May 24, 2017, in Room 643 of the Legislative Office Building. Twelve members were present.

Sen. Louis Pate, Chair, presided.

Sen. Pate opened the meeting by recognizing the pages–Elizabeth Pridgen of Kenly, McCall Holland of Ocean Isle Beach, Weston Cregger of Concord, Callie Mahaley of Kannapolis, Tyler Hicks of Davidson, Bryson Rose of Concord, and Alex Balla of Raleigh. He also recognized the Sergeants-at-Arms–Terry Edmondson, Jim Hamilton, and Linda Matthews.

Sen. Pate recognized Rep. Lambeth to present HB 283–DHHS Recommend Telemedicine Policy. Sen. Woodard moved for a favorable report to the bill. The motion passed.

Sen. Pate explained that federal law requires a legislative hearing every three years in conjunction with development of the state plan for community services block grant. He then recognized Freeman L. Denton, Interim Director, Division of Social Services Office of Economic Opportunity, NC Department of Health and Human Services, for a presentation on NC Community Services Block Grant State Plan (attached).

Following the presentation, Sen. Pate opened the floor for Senate members' questions and discussion, as well as statements by eight members of the public.

The meeting adjourned at 11:05 AM.

Senator Louis Pate, Chair
Presiding

Susan Fanning, Committee Clerk

Senate Committee on Health Care
Wednesday, May 24, 2017, 10:00 AM
643 Legislative Office Building

AGENDA
Senator Pate, Presiding

Welcome and Opening Remarks

Introduction of Pages

Presentations

Presentation on NC Community Services Block Grant State Plan
Freeman L. Denton
Interim Director, Division of Social Services Office of Economic Opportunity
North Carolina Department of Health and Human Services

Comments on the State Plan by Members of the Public
(Members of the public interested in commenting on the Plan should sign up to speak.)

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 283	DHHS Recommend Telemedicine Policy.	Representative Lambeth Representative Insko Representative Murphy Representative Dobson

Adjournment

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	May 24, 2017	10:00 AM	643 LOB

Legislative Hearing for the North Carolina Community Services Block Grant State Plan

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

Principal Clerk ____
Reading Clerk ____

Corrected #1: HB 283 has been added.

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	May 24, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 283	DHHS Recommend Telemedicine Policy.	Representative Lambeth Representative Insko Representative Murphy Representative Dobson

Legislative Hearing for the North Carolina Community Services Block Grant State Plan

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

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, May 24, 2017

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

FAVORABLE

HB **283** **(CS#1)** DHHS Recommend Telemedicine Policy.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle HB 283

HOUSE BILL 283
Committee Substitute Favorable 4/5/17

Short Title: DHHS Recommend Telemedicine Policy. (Public)

Sponsors:

Referred to:

March 9, 2017

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND RECOMMEND A TELEMEDICINE POLICY.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall study and recommend a telemedicine policy for consideration by the General Assembly. At a minimum, the Department shall examine telemedicine/telehealth laws in other states as they pertain to the elements outlined below and recommend standards for the State:

(1) A definition of the term telemedicine.
(2) The scope of services that can be covered by telemedicine.
(3) Acceptable communication and data transfer standards necessary to ensure the privacy of health information and appropriate for insurance reimbursement.
(4) Informed consent standards.
(5) Online prescribing standards.
(6) Telemedicine provider licensing standards.
(7) Private payer telemedicine reimbursement standards.

The Department shall solicit input from relevant stakeholders and from the Department of Insurance on the potential insurance impact of particular telemedicine policy elements. While conducting this study, the Department may examine services reimbursed under the Medicaid policy, but the recommendations shall not include changes to the State's Medicaid policy.

SECTION 2. On or before October 1, 2017, the Department of Health and Human Services shall submit a report containing findings and recommendations and a proposed telemedicine policy to the Joint Legislative Oversight Committee on Health and Human Services. Based on the Department's report, the Committee shall consider making a recommendation to the 2017 General Assembly during the 2018 Regular Session.

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

HOUSE BILL 283:
DHHS Recommend Telemedicine Policy.

2017-2018 General Assembly

Committee:	Senate Health Care	**Date:**	May 17, 2017
Introduced by:	Reps. Lambeth, Insko, Murphy, Dobson	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	Second Edition		

OVERVIEW: HB 283 would require the Department of Health and Human Services to study and recommend a telemedicine policy to the Joint Legislative Oversight Committee on Health and Human Services on or before October 1, 2017. The bill would become effective when it becomes law.

CURRENT LAW: Currently, North Carolina does not have laws pertaining to telemedicine that provide the policy for the State, including standards or any limitations and safeguards for protecting the public. There are several references to telemedicine in current statutes as they pertain to particular programs.[1]

BILL ANALYSIS: Section 1 of House Bill 283 would require the Department of Health and Human Services to study and recommend a telemedicine policy for consideration by the General Assembly. At a minimum, the Department shall examine the elements below as contained in telemedicine/telehealth laws in other states and make recommendations for telemedicine standards in North Carolina.

- A definition of the term telemedicine.
- The scope of services that can be covered by telemedicine.
- Acceptable communication and data transfer standards necessary to ensure the privacy of health information and appropriate for insurance reimbursement.
- Informed consent standards.
- Online prescribing standards.
- Telemedicine provider licensing standards.
- Private payer telemedicine reimbursement standards.

The Department is required to solicit input from relevant stakeholders and from the Department of Insurance on the potential insurance impact of telemedicine policy elements. During the study, the Department may examine services reimbursed under the Medicaid policy, but the recommendations shall not include changes to the State's Medicaid policy.

Section 2 of the bill contains the reporting requirement. On or before October 1, 2017, the Department of Health and Human Services is required to submit a report containing findings and recommendations and a proposed telemedicine policy to the Joint Legislative Oversight Committee on Health and Human Services. Based on the Department's report, the Committee must consider making a recommendation to the 2017 General Assembly during the 2018 Regular Session.

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

[1] G.S. 130A-125 and G.S. 122C-263(c).

Karen Cochrane-Brown
Director

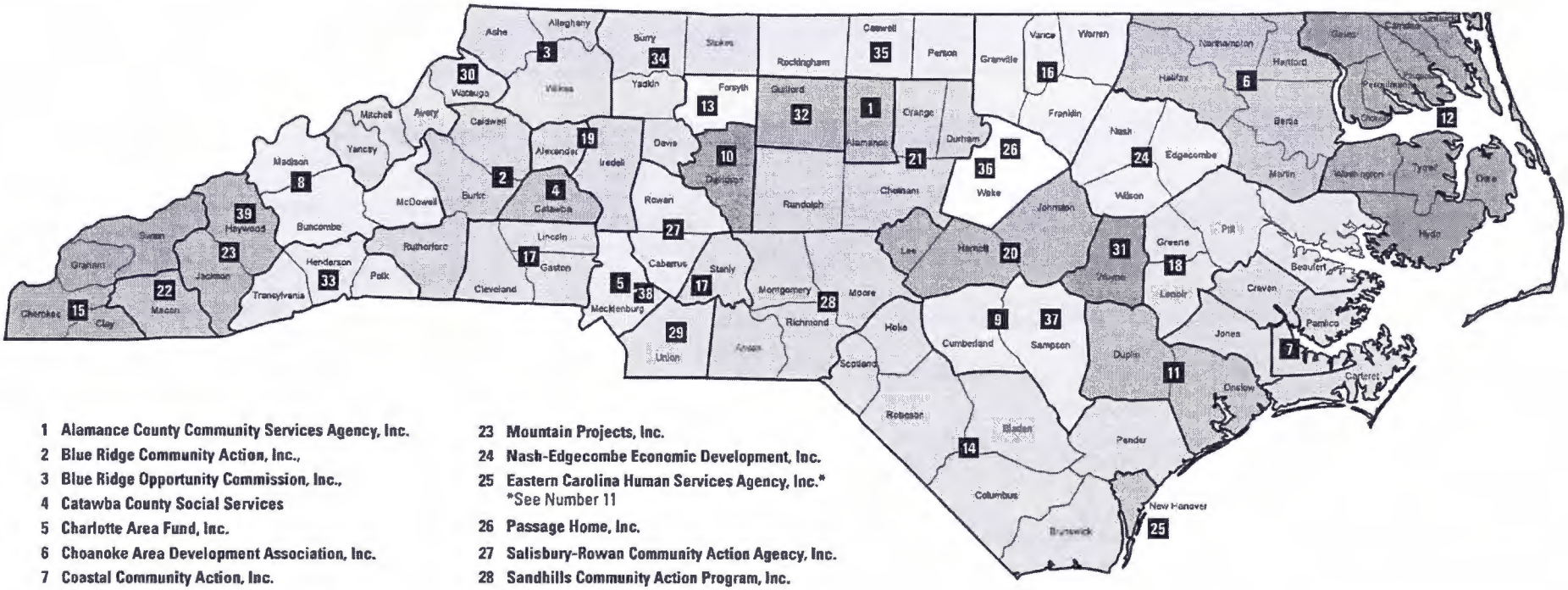
H283-SMSH-49 E2 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

BACKGROUND: The range of polices on telehealth/telemedicine varies by State. Within a given state, the telemedicine policy covers a range of options including: what constitutes telehealth/telemedicine, how it is defined, and what services and providers are eligible. The National Conference of State Legislatures has compiled a good bit of information and a number of reports on telehealth services. The Center for Connected Health Policy has produced a document on State Telehealth Laws and Medicaid Program Policies, A Comprehensive Scan of the 50 States and District of Columbia. This document demonstrates the array of options that exist in each state and may serve as a starting point for the Department's study.

North Carolina Community Action Agencies and Limited Purpose Agencies



1 **Alamance County Community Services Agency, Inc.**
2 **Blue Ridge Community Action, Inc.,**
3 **Blue Ridge Opportunity Commission, Inc.,**
4 **Catawba County Social Services**
5 **Charlotte Area Fund, Inc.**
6 **Choanoke Area Development Association, Inc.**
7 **Coastal Community Action, Inc.**
8 **Community Action Opportunities, Inc.**
9 **Action Pathways, Inc.+**
+Formerly Cumberland Community Action Program, Inc.
10 **Davidson County Community Action, Inc.**
11 **Eastern Carolina Human Services Agency, Inc.**
12 **Economic Improvement Council, Inc.**
13 **Experiment In Self-Reliance, Inc.**
14 **Southeastern Community And Family Services, Inc.**
15 **Four Square Community Action, Inc.**
16 **Franklin-Vance-Warren Opportunity, Inc.**
17 **Gaston Community Action, Inc.**
18 **Greene Lamp, Inc.**
19 **I-Care, Inc.**
20 **Johnston-Lee-Harnett Community Action, Inc.**
21 **Central Piedmont Community Action, Inc.**
(formerly Joint Orange-Chatham Community Action, Inc.)
22 **Macon Program For Progress, Inc.**
23 **Mountain Projects, Inc.**
24 **Nash-Edgecombe Economic Development, Inc.**
25 **Eastern Carolina Human Services Agency, Inc.***
*See Number 11
26 **Passage Home, Inc.**
27 **Salisbury-Rowan Community Action Agency, Inc.**
28 **Sandhills Community Action Program, Inc.**
29 **Union County Community Action, Inc.**
30 **W.A.M.Y. Community Action, Inc.**
31 **Wayne Action Group For Economic Solvency, Inc.**
32 **Welfare Reform Liaison Project, Inc.**
33 **Western Carolina Community Action, Inc.**
34 **Yadkin Valley Economic Development District, Inc.**
35 **Telamon Corporation**

*LIMITED PURPOSE AGENCIES
36 **North Carolina Commission Of Indian Affairs**
37 **Telamon Corporation**
38 **Mosaic Development Group**
(formerly The Affordable Housing Group, Inc.)
39 **Western Economic Development Organization**

FOR COMPLETE COUNTY LISTING INFORMATION AND PHONE NUMBERS, SEE REVERSE

North Carolina Community Action Association

Connect. Advocate. Innovate.

N.C. Community Action Association

4428 Louisburg Road
Suite 101
Raleigh, NC 27616
Phone: 919-790-5757
Fax: 919-790-5767

www.nccaa.net

North Carolina Community Action Agencies and Limited Purpose Agencies

1 **ALAMANCE COUNTY COMMUNITY SERVICES AGENCY, INC.**, Burlington (336) 229-7031
Alamance County

2 **BLUE RIDGE COMMUNITY ACTION, INC.**, (828) 438-6255
Morganton
Burke, Caldwell, and Rutherford Counties

3 **BLUE RIDGE OPPORTUNITY COMMISSION, INC.**, N. Wilkesboro (336) 667-7174
Alleghany, Ashe and Wilkes Counties

4 **CATAWBA COUNTY SOCIAL SERVICES,** (828) 695-5600
Newton
Catawba County

5 **CHARLOTTE AREA FUND, INC.**, (704) 372-3010
Charlotte
Mecklenburg County

6 **CHOANOKE AREA DEVELOPMENT ASSOCIATION, INC.**, Rich Square (252) 539-4155
Bertie, Halifax, Hertford, Martin and Northampton Counties

7 **COASTAL COMMUNITY ACTION, INC.**, (252) 223-1630
Newport
Carteret, Craven, Jones and Pamlico Counties

8 **COMMUNITY ACTION OPPORTUNITIES, INC.**, (828) 252-2495
Asheville
Buncombe, Madison and McDowell Counties

9 **ACTION PATHWAYS INC.+** (910) 485-6131
Fayetteville or 485-6923
Cumberland and Sampson Counties

10 **DAVIDSON COUNTY COMMUNITY ACTION, INC.**, Lexington (336) 249-0234
Davidson County

11 **EASTERN CAROLINA HUMAN SERVICES AGENCY, INC.**, Jacksonville (910) 347-2151
Duplin, Onslow, and New Hanover Counties

12 **ECONOMIC IMPROVEMENT COUNCIL, INC.**, Edenton (252) 482-4459
Camden, Chowan, Currituck, Dare, Gates, Hyde,
Pasquotank, Perquimans, Tyrrell and Washington Counties

13 **EXPERIMENT IN SELF-RELIANCE, INC.**, (336) 722-9400
Winston-Salem
Forsyth County

14 **SOUTHEASTERN COMMUNITY AND FAMILY SERVICES, INC.**, Lumberton (910) 277-3521
Bladen, Brunswick, Columbus, Hoke, Pender,
Robeson and Scotland Counties

+Formerly Cumberland Community Action Program, Inc.

15 **FOUR SQUARE COMMUNITY ACTION, INC.**, (828) 321-4475
Andrews
Cherokee, Clay, Graham and Swain Counties

16 **FRANKLIN-VANCE-WARREN OPPORTUNITY, INC., Henderson** (252) 492-0161
1-800-682-1163
Franklin, Granville, Vance, and Warren Counties

17 **GASTON COMMUNITY ACTION, INC.**, (704) 861-2283
Gastonia
Cleveland, Gaston, Lincoln and Stanly Counties

18 **GREENE LAMP, INC.**, Kinston (252) 523-7770
Beaufort, Greene, Lenoir, and Pitt Counties

19 **I-CARE, INC.**, Statesville (704) 872-8141
Iredell and Alexander Counties

20 **JOHNSTON-LEE-HARNETT COMMUNITY ACTION, INC.**, Smithfield (919) 934-2145
Harnett, Johnston and Lee Counties

21 **CENTRAL PIEDMONT COMMUNITY ACTION, INC.** (919) 742-2277
(formerly JOINT ORANGE-CHATHAM COMMUNITY ACTION, INC.,) Pittsboro
Chatham, Durham, Orange, and Randolph Counties

22 **MACON PROGRAM FOR PROGRESS, INC.**, (828) 524-4471
Franklin
Macon County

23 **MOUNTAIN PROJECTS, INC.**, Waynesville (828) 452-1447
Haywood and Jackson Counties

24 **NASH-EDGECOMBE ECONOMIC DEVELOPMENT, INC.**, Rocky Mount (252) 442-8081
Edgecombe, Nash and Wilson Counties

25 ***See #11 EASTERN CAROLINA HSA, INC.** (910) 347-2151
New Hanover County

26 **PASSAGE HOME, INC.**, Raleigh (919) 834-0666
Wake County

27 **SALISBURY-ROWAN COMMUNITY ACTION AGENCY, INC.**, Salisbury (704) 633-6633
Cabarrus and Rowan Counties

28 **SANDHILLS COMMUNITY ACTION PROGRAM, INC.**, Carthage (910) 947-5675
Anson, Montgomery, Moore and Richmond Counties

29 **UNION COUNTY COMMUNITY ACTION, INC.**, (704) 283-7583
Monroe
Union County

30 **W.A.M.Y. COMMUNITY ACTION, INC.**, (828) 264-2421
Boone
Avery, Mitchell, Watauga and Yancey Counties

31 **WAYNE ACTION GROUP FOR ECONOMIC SOLVENCY, INC.**, Goldsboro (919) 734-1178
Wayne County

32 **WELFARE REFORM LIAISON PROJECT, INC.**, Greensboro (336) 691-5780
Guilford County

33 **WESTERN CAROLINA COMMUNITY ACTION, INC.**, Henderson (828) 693-1711
Henderson, Transylvania, and Polk Counties

34 **YADKIN VALLEY ECONOMIC DEVELOPMENT DISTRICT, INC.**, Boonville (336) 367-7251
Davie, Stokes, Surry, and Yadkin Counties

35 **TELAMON CORPORATION**, Raleigh (919) 239-8111
Caswell, Person and Rockingham Counties

Limited Purpose Agencies

36 **NORTH CAROLINA COMMISSION OF INDIAN AFFAIRS**, Raleigh (919) 807-4440
Statewide

37 **TELAMON CORPORATION**, Raleigh (919) 239-8111
Sampson County

38 **MOSAIC DEVELOPMENT GROUP** (704) 342-3316
(formerly THE AFFORDABLE HOUSING GROUP, INC.), Charlotte
Statewide

39 **WESTERN ECONOMIC DEVELOPMENT ORGANIZATION**, Waynesville (828) 452-7585
Haywood

OFFICE of ECONOMIC OPPORTUNITY

NC DHHS Division of Social Service Office of Economic Opportunity
North Carolina's Community Services Block Grant Program **(CSBG)**
FFY 2018 and 2019 State Plan Overview

Federal Legislation
Community Opportunities, Accountability, And Training And Educational Services Act of 1998

North Carolina State Rules:
10A NCAC 97

Goal/Purpose (Poverty Elimination)
To reduce poverty, revitalize low-income communities and they are empowered low-income families and individuals *to rise above the official poverty guidelines and become economically independent. (1) Services are provided in communities where poverty is an acute problem; (2) activities such as (education, employment, income management, basic life skills, family supports – housing, child care, transportation) are designed to assist low-income participants, including the elderly poor, (3) emergency assistance is provided (inclusive of rent/mortgage, utilities, medical/healthcare supports, etc.) such as supplies and services, nutrition supports and related services to counteract conditions of starvation and malnutrition among the poor; and (4) linkages are coordinated between governmental and other human services programs to assure the effective delivery of such services to low-income individuals.*

Funding
Planned Distribution of Funds for State Fiscal Years 2018-19 and 2019-20

Distribution Category	% Distribution	SFY 2018-19 PROJECTED ALLOCATION	SFY 2019-20 PROJECTED ALLOCATION
Eligible Entities	90%	$16,812,278	$16,812,278
Limited Purpose Agencies/ Discretionary	5%	$934,015	$934,015
State Administration	5%	$934,015	$934,015
Total	100%	$ 18,680,308	$ 18,680,308

Use of Funds

Planned CSBG 90 Percent Funds/ CSBG Eligible Entities		
CSBG Eligible Entity	**Year One (SFY 2018-19)**	**Year Two (SFY 2019-20)**
	Funding Amount	**Funding Amount**
Action Pathways, Inc.	$867,001*	$751,535
Alamance County Community Services Agency, Inc.	$263,212	$300,182
Blue Ridge Community Action, Inc.	$366,453*	$412,351
Blue Ridge Opportunity Commission, Inc.	$212,053*	$211,344
Catawba County Department of Social Services	$222,191*	$238,273
Central Piedmont Community Action	$1,040,606*	$1,028,304
Charlotte Area Fund	$1,740,232*	$1,506,058
Choanoke Area Development Association, Inc.	$318,303	$363,012
Coastal Community Action, Inc.	$282,548*	$289,783
Community Action Opportunities, Inc.	$495,760*	$514,452
Davidson County Community Action, Inc.	$215,747*	$237,518
Eastern Carolina Human Services Agency, Inc.	$787,826*	$806,374
Economic Improvement Council, Inc.	$248,297*	$271,062
Experiment in Self-Reliance, Inc.	$683,378*	$671,567
Four Square Community Action, Inc.	$124,760*	$120,000
Franklin-Vance-Warren Opportunity, Inc.	$403,323*	$359,290
Gaston Community Action, Inc.	$710,504*	$783,622
Greene Lamp, Inc.	$723,217*	$732,070
ICARE, Inc.	$267,753	$305,361
Johnston-Lee-Harnett Community Action, Inc.	$538,380*	$578,253
Macon Program for Progress	$127,246*	$120,000
Mountain Projects, Inc.	$238,284*	$214,681
Nash-Edgecombe Economic Development, Inc.	$429,139	$489,415
Passage Home	$1,008,823	$1,150,520
Salisbury-Rowan Community Action Agency, Inc.	$579,181*	$459,592
Sandhills Community Action Program, Inc.	$337,595*	$373,380
Southeastern Community & Family Services, Inc.	$1,016,600*	$1,104,375
Telamon Corporation	$374,375*	$282,919
Union County Community Action, Inc.	$261,121*	$221,185
WAMY Community Action, Inc.	$322,809*	$318,826
Wayne Action Group for Economic Solvency, Inc.	$221,399*	$230,179
Welfare Reform Liaison Project, Inc.	$857,308*	$814,396
Western Carolina Community Action, Inc.	$201,658	$229,982
Yadkin Valley Economic Development District, Inc.	$325,196*	$322,417
Total	**$16,812,278**	**$16,812,278**
*Note: SFY 2018-19 allocations include anticipated agency specific carry-forward funding and are subject to change.		

Use of Funds (Continued)

Planned Use of Remainder/Discretionary Funds (5 Percent)			
Remainder/ Discretionary Fund Uses (See 675C(b)(1) of the CSBG Act)	**Year One (SFY 2018-19)** **Planned $ Planned %**	**Year Two (SFY 2019-20)** **Planned $ Planned %**	**Brief description of services/activities**
Training/technical assistance to eligible entities	$233,504 25%	$280,205 30%	Training/ Technical Assistance will focus on strengthening agency capacity, mitigating risk and compliance with organizational standards and accountability measures outlined in the Performance Management Framework
Statewide coordination and communication among eligible entities	$233,504 25%	$373,605 40%	Funding will support outcome tracking and performance reporting at the local and state levels.
Analysis of distribution of CSBG funds to determine if targeting greatest need	$74,721 8%		The distribution method for the 5% discretionary and 90% eligible entity funding will be examined in conjunction with this assessment to inform funding methodology for maximizing allocations for poverty reduction.
Innovative programs/ activities by CAAs or other neighborhood groups (may include fatherhood and strengthening families initiatives)		$280,205 30%	The assessment of needs completed in Year 1 in conjunction with national performance management efforts and other relevant sources will be utilized to identify target areas for funding
Other activities, specify: Limited Purpose Agencies (Affordable Housing Group of NC, NC Commission on Indian Affairs, Telamon Corporation, Western Economic Development Organization	$392,286 42%		The North Carolina Administrative Code currently specifies these agencies to receive discretionary funding. Four Limited Purpose Agencies operating projects for a specific target population or specific program area will be funded with 42% of the discretionary allocation. The projects will target: American Indians, Workforce Preparation for ESOL population, Housing and Education.
	$934,015 100%	**$934,015 100%**	
Note: all funding proposed above is dependent upon pending proposed changes within the NC Administrative Code.			

State Administration (5 Percent)	Year One (SFY 2018-19)	Year Two (SFY 2019-20)
State Office Administration- funds used by the N.C. DHHS– Division of Social Services Office of Economic Opportunity to provide whole-health agency monitoring and training/technical assistance to program grantees to ensure compliance with federal rules and regulations and department level support for anti-poverty and human service programs.	$934,015	$934,015
Total	**$934,015**	**$934,015**

Local Level Administration (Tripartite Board Requirement)

- CSBG is administered on the local level through a tripartite board structure which is mandated to include persons that are low-income and/or representatives of low-income families because this facet of CSBG administration gives low-income families "voice" and responsibility for addressing the conditions of poverty.

- Being active in the administration of the program moves low-income families from a posture of being 'subject to' available anti-poverty programming to 'shared governance in' available anti-poverty programming which teaches leadership, accountability and integrity, traits that are important for developing law-abiding, contributing and upstanding citizens.

Monitoring and Accountability

Monitoring activities of the state administering agency will include reviews of eligible entities, as required under Section 676B(a) of the Act

- A full onsite review of each such entity at least once during each 3-year period;
- An onsite review of each newly designated entity immediately after the completion of the first year in which such entity receives funds through the Community Services Block Grant Program;
- Follow-up reviews including prompt return visits to eligible entities, and their programs, that fail to meet the goals, standards, and requirement established by the State;
- Other reviews as appropriate, including reviews of entities with programs that have had other Federal, State or local grants (other than assistance provided under the Community Services Block Grant Program) terminated for cause.

Reporting

- All North Carolina eligible entities are required to submit a federally required report which details how CSBG expenditures, agency wide resources and agency wide outcomes.

- All North Carolina eligible entities are required to report key contracted outcomes specific to CSBG funding.

Performance Management Framework:
National Efforts to Increase Accountability and Effectiveness

- **State and Federal Accountability Measures**: developed by the Urban Institute, are designed to strengthen State and Federal CSBG administrator accountability in achieving the overall goals of the CSBG program.

- **CSBG-Eligible Entity Organizational Standards**, developed by the Organizational Standards Center of Excellence at the Community Action Partnership, will strengthen the capacity of the more than 1,100 CSBG-eligible entities to fulfill their anti-poverty missions.

- **Results Oriented Management and Accountability (ROMA) Next Generation / Revised CSBG Annual Report**, an effort led by the ROMA Center of Excellence at National Association for State Community Service Programs, is a revised national annual report for Community Action Agencies.

North Carolina Amended Plan Community Services Block Grant FFY 2018 - 2019

May 24, 2017
Legislative Hearing
Senate Committee on Health Care
Raleigh, North Carolina

Requirements

Federal Law (Sec. 676 of the Community Opportunities, Accountability, And Training And Educational Services Act Of 1998; Public Law 105-285) requires one hearing in the State and at least one legislative hearing every three years in conjunction with development of the state plan.

2

CSBG Service Delivery System

Composed of 34 Community Action Agencies (CAAs) and 4 Limited Purpose Agencies (LPAs)

Assist individuals and families with moving from poverty to economic independence

Serve all 100 of North Carolina Counties

3

Governance

Required Tripartite Board Structure:

Offers opportunity for the low-income population, public elected officials (or representatives) and private sector representative to work together for the oversight, development, and evaluation of community programs.

Gives low-income families "voice" and responsibility for addressing the conditions of poverty, teaching leadership and accountability.

4

Proposed Change

- Proposed Amendments to the North Carolina Administrative Code (NCAC) Chapter 97 to update information based on Office of Economic Opportunity location; maximize the use of available discretionary funding through aligning state rules with allowable use under federal regulations; general updates to reflect current practices/ operations.

5

Monitoring & Accountability

- Monitoring begins with the annual funding application and continues through the closeout of each grant year.
- On-site reviews occur:
  - After completion of first year;
  - As needed based on requirements and/or compliance issues; and
  - Every three years as mandated.

6

Who Does North Carolina Community Action Agencies Serve?

- **113,503 unduplicated persons served**
  - 108,839 unduplicated persons about whom one or more characteristics were obtained
  - 4,664 unduplicated persons about whom no characteristics were obtained
- **62,751 unduplicated families served**
  - 58,319 unduplicated families about whom one or more characteristics were obtained
  - 4,432 unduplicated families about whom no characteristics were obtained

Source: FY 2015 CSBG-IS Report

7

SFY 2015-16 Outcome Achievement for CSBG Self-Sufficiency Programs

Families receiving services	8,536
Families rising above the poverty level	683
Families obtaining employment	1,005
Families obtaining better employment	359
The average change in annual income	$10,846
The average wage rate	$9.85
Families obtaining jobs with medical benefits	197
Families completing education/training programs	877
Families securing standard housing	464
Families provided employment support	1,409
Families provided education support	1,331
Families provided emergency assistance	1,323

Source: SFY 2015-16 ear-End Report

8

Questions

North Carolina Plan for Administering
Community Services Block Grant Program
FFY 2018 and 2019

9

Community Services Block Grant (CSBG) Model State Plan

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Mandatory Grant Application SF-424

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Section 4: CSBG Hearing Requirements
Section 5: CSBG Eligible Entities
Section 6: Organizational Standards for Eligible Entities
Section 7: State Use of Funds
Section 8: State Training and Technical Assistance
Section 9: State Linkages and Communication
Section 10: Monitoring, Corrective Action, and Fiscal Controls
Section 11: Eligible Entity Tripartite Board
Section 12: Individual and Community Income Eligibility Requirements
Section 13: Results Oriented Management and Accountability (ROMA) System
Section 14: CSBG Programmatic Assurances and Information Narrative
Section 15: Federal Certifications

DRAFT

SECTION 1
CSBG Lead Agency, CSBG Authorized Official, CSBG Point of Contact, and Official State Designation Letter

1.1. Provide the following information in relation to the lead agency designated to administer CSBG in the State, as required by Section 676(a) of the CSBG Act. The following information should mirror the information provided on the Application for Federal Assistance, SF-424M.

1.1a. Lead agency North Carolina Department of Health and Human Services, Division of Social Services, Office of Economic Opportunity

1.1b. Cabinet or administrative department of this lead agency

- ☐ Community Services Department
- ☑ Human Services Department
- ☐ Social Services Department
- ☐ Governor's Office
- ☐ Community Affairs Department
- ☐ Other, describe:

1.1c. Division, bureau, or office of the CSBG authorized official

North Carolina Department of Health and Human Services, Secretary's Office

1.1d. Authorized official of the lead agency Dr. Mandy Cohen

1.1e. Street address 101 Blair Drive

1.1f. City Raleigh

1.1g. State North Carolina

1.1h. Zip 27603

1.1i. Telephone number and extension 919-855-4800

1.1j. Fax number 919-715-4645

1.1k. Email address Mandy.Cohen@dhhs.nc.gov

1.1l. Lead agency website http://www.ncdhhs.gov/

1.2. Provide the following information in relation to the designated State CSBG point of contact.

1.2a. Agency name Division of Social Services, Office of Economic Opportunity

1.2b. Name of the point of contact Freeman Denton

1.2c. Street address 820 S. Boylan Avenue, Hargrove Building

1.2d. City Raleigh

1.2e. State North Carolina

1.2f. Zip 27603

1.2g. Point of contact telephone number 919-527-6250

1.2h. Fax number 919-334-1265

1.2i. Point of contact email address freeman.denton@dhhs.nc.gov

1.2j. Point of contact agency website http://www.ncdhhs.gov/oeo/

1.3. **Designation Letter:** Attach the State's official CSBG designation letter. If either the governor or designated agency has changed, update the letter accordingly.

To be attached upon submission

DRAFT

SECTION 2
State Legislation and Regulation

2.1. **CSBG State Legislation:** Does the State have a statute authorizing CSBG? ☑ Yes ☐ No

2.2. **CSBG State Regulation:** Does the State have regulations for CSBG? ☑ Yes ☐ No

2.3. If yes was selected in item 2.1 or 2.2, attach a copy (or copies) of legislation and/or regulations or provide a hyperlink(s), as appropriate.

North Carolina Statute Authorizing Federal Block Grants

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143C/GS_143C-7-2.html

State CSBG Regulations 10A North Carolina Administrative Code Chapters 97A-C

http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 10A - Health and Human Services\Chapter 97 - Economic Opportunity

2.4. **State Authority:** Select a response for each question about the State statute and/or regulations authorizing CSBG:

2.4a. Did the State legislature enact authorizing legislation, or amendments to an existing authorizing statute, last year? ☐ Yes ☑ No

2.4b. Did the State establish or amend regulations for CSBG last year? ☐ Yes ☑ No

2.4c. Does the State statutory or regulatory authority designate the bureau, division, or office in the State government that is to be the State administering agency? ☑ Yes ☐ No

DRAFT

SECTION 3
State Plan Development and Statewide Goals

3.1. **CSBG Lead Agency Mission and Responsibilities:** Briefly describe the mission and responsibilities of the State agency that serves as the CSBG lead agency. The mission of the Division of Social Service's Office of Economic Opportunity is to administer grant programs that provide opportunities for low-income individuals and families to become self-sufficient through the provision of financial resources to Community Action Agencies, and Limited Purposes Agencies, for programs that will substantially reduce the number of citizens in our state who are living in poverty. Responsibilities of the Office of Economic Opportunity are specified in Title 10A North Carolina Administrative Code, Chapter 97A .0101 and are available at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 10A - Health and Human Services\Chapter 97 - Economic Opportunity and have been attached to the OLDC System.

3.2. **State Plan Goals:** Describe the State's CSBG-specific goals for State administration of CSBG under this State Plan.

The primary goal of the North Carolina Community Services Block Grant Program is to provide funding to Community Action Agencies to carry out activities that will enable low-income families to move out of poverty. Community Services Block Grant specific goals under this plan include:

(i) Increase the number of families attaining economic self-sufficiency (income above the poverty level based on household size).

(ii) Improve the administrative efficiency of the Office through staff training and development and integration of the use of automation technology in all aspects of office operations.

(iii) Build grantee and community capacity to plan, develop and deliver services.

(iv) Develop partnerships and collaborate with Departmental Divisions, other state agencies, public and private human service organizations to promote more effective utilization of existing resources.

(v) Ensure results-based performance management through monitoring, assessment and evaluation standards.

3.3. **State Plan Development:** Indicate the information and input the State accessed to develop this State Plan.

3.3a. Analysis of

☑ State Performance Indicators and/or National Performance Indicators (NPIs)

☑ U.S. Census data

☑ State performance management data (e.g., accountability measures, ACSI survey information, and/or other information from annual reports)

☐ Other data (describe) **[Narrative, 2500 characters]**

☑ Eligible entity community needs assessments

☑ Eligible entity plans

☑ Other information from eligible entities, e.g., State required reports (describe) Organizational Standards assessments

3.3b. Consultation with

☑ Eligible entities (e.g., meetings, conferences, webinars; not including the public hearing)

☑ State community action association and regional CSBG T & TA providers

☑ State partners and/or stakeholders The Social Services Commission, comprised of individuals appointed by the Governor, have the authority and responsibility for facilitating the public hearing, reviewing and approving of the CSBG State Plan submission.

☑ National organizations State staff work with organizations such as National Association of State Community Services Programs, Office of Community Services and Community Action Partnerships on a regular basis which informs content submitted within the state plan

☐ Other (describe)

3.4. Eligible Entity Involvement

3.4a. Describe the specific steps the State took in developing the State Plan to involve the eligible entities.

Eligible entities were involved in the development of the State Plan through four regional meetings held April 24-28, 2017. Office of Economic Opportunity, in partnership with the NC Community Action Association, provided an overview of key areas of the state plan and received feedback. Additionally, eligible entities will be provided updates regarding the development and review of the state plan via e-mail correspondence, public review/ comment periods and public hearing. These forms of engagement and communication serve the dual purpose of providing eligible entities information and seeking feedback/ suggestions for the State Plan. Specific focus of overview and feedback was placed on organizational standards, American Customer Service Index results, areas of targeted performance, training

and technical assistance, areas of the state plan that are connected to the overall performance management framework outlined from the Office of Community Services and state office communications plan. Lastly, state staff completed review of needs assessments and performance data submitted by eligible entities to inform the development of the State Plan.

3.4b. Performance Management Adjustment: How has the State adjusted State Plan development procedures under this State Plan, as compared to past plans, in order 1) to encourage eligible entity participation and 2) to ensure the State Plan reflects input from eligible entities? Any adjustment should be based on the State's analysis of past performance in these areas, and should consider feedback from eligible entities, OCS, and other sources, such as the public hearing. If the State is not making any adjustments, provide further detail.

- NC Division of Social Services Office of Economic Opportunity (OEO) and the NC Community Action Association (NCCAA) are completing the Regional Performance Innovation Consortium (RPIC) Combined Training and Technical Assistance Plan Template provided as part of the Organizational Standards Center of Excellence (OSCOE)
- NC Division of Social Services Office of Economic Opportunity (OEO) and the NC Community Action Association (NCCAA) collaborated on Training and Technical Assistance Survey released to the NC Community Action Network to inform T/TA efforts to be included in the state plan
- NC Division of Social Services Office of Economic Opportunity (OEO) has shared the results of organizational standards assessments and the American Customer Service Index with NC Community Action Network to inform efforts included within the state plan
- NC Division of Social Services Office of Economic Opportunity (OEO) in partnership with the NC Community Action Association, provided an overview of key areas of the state plan and received feedback from eligible entities through four regional meetings held April 24-28, 2017.

3.5. Eligible Entity Overall Satisfaction: Provide the State's target for eligible entity Overall Satisfaction during the performance period: 61.

SECTION 4

CSBG Hearing Requirements

4.1. Public Inspection: Describe how the State made this State Plan, or revision(s) to the State Plan, available for public inspection, as required under Section 676(e)(2) of the Act.
The State Plan was made available for public inspection and comment **TO BE INSERTED UPON SUBMISSION**. The State Plan and relevant notices were posted on the North Carolina Department of Health and Human Services, Division of Social Services' Office of Economic Opportunity website; Community Action Agencies, Limited Purpose Agencies and the North Carolina Community Action Association were encouraged to make the plan available at their locations for stakeholder and public review; a notice on the period of public inspection appeared in the legal section of newspapers having statewide or regional distribution; and all Community Action Agencies, Limited Purpose Agencies and the North Carolina Community Action Association were notified by e-mail of the public inspection/ comment period and the public hearing. The public hearing for North Carolina's State Plan for Administering the Community Services Block Grant Program in Fiscal Years 2018 and 2019 was held on **TO BE INSERTED UPON SUBMISSION** at 820 South Boylan Avenue, Raleigh, NC 27603 in the McBryde Building on Dorothea Dix Campus.

4.2. Public Notice/Hearing: Describe how the State ensured there was sufficient time and statewide distribution of notice of the public hearing(s) to allow the public to comment on the State Plan, as required under 676(a)(2)(B) of the CSBG Act.

North Carolina's State Plan for Administering the Community Services Block Grant Program in Fiscal Years 2018 and 2019 was made available for public review and comment (**TO BE INSERTED UPON SUBMISSION)**. Notifications of the inspection period and public hearing were made via e-mail, legal section of newspapers having statewide distribution and state website postings. In addition, the State Office, in partnership with NC Community Action Association, facilitated for in-person sessions providing an overview of key areas of the state plan and received feedback April 24-28, 2017.

4.3. Public and Legislative Hearings: Specify the date(s) and location(s) of the public and legislative hearing(s) held by the designated lead agency for this State Plan, as required under Section 676(a)(2)(B) and Section 676(a)(3) of the Act. (If the State has not held a public hearing in the prior fiscal year and/or a legislative hearing in the last three years, provide further detail).

Date	Location	Type of Hearing [Select an option]
TBD	TBD	• Public
TBD	TBD	• Legislative

4.4. Attach supporting documentation or a hyperlink for the public and legislative hearings.

(Legislative Hearing Minutes) - **To be attached upon submission**

(Public Hearing Minutes) – **To be attached upon submission**

SECTION 5
CSBG Eligible Entities

5.1. **CSBG Eligible Entities:** In the table below, list each eligible entity in the State, and indicate public or private, the type(s) of entity, and the geographical area served by the entity. (This table should include every CSBG Eligible Entity to which the State plans to allocate 90 percent funds, as indicated in the table in item 7.2. Do not include entities that only receive remainder/discretionary funds from the State or tribes/tribal organizations that receive direct funding from OCS under Section 677 of the CSBG Act.)

CSBG Eligible Entity	Public or Nonprofit	Type of Agency	Geographical Area Served	Brief Description of "Other"
Action Pathways, Inc.	Nonprofit	CAA	Cumberland and Sampson Counties	N/A
Alamance County Community Services Agency, Inc.	Nonprofit	CAA	Alamance County	N/A
Blue Ridge Community Action, Inc.	Nonprofit	CAA	Burke, Caldwell, Rutherfordton Counties	N/A
Blue Ridge Opportunity Commission, Inc.	Nonprofit	CAA	Allegany, Ashe and Wilkes Counties	N/A
Catawba County Department of Social Services	Public	CAA	Catawba County	N/A
Central Piedmont Community Action, Inc.	Nonprofit	CAA	Chatham, Durham, Orange and Randolph Counties	N/A

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CSBG Eligible Entity	Public or Nonprofit	Type of Agency	Geographical Area Served	Brief Description of "Other"
Charlotte Area Fund	Nonprofit	CAA	Mecklenburg County	N/A
Choanoke Area Development Association, Inc.	Nonprofit	CAA	Bertie, Halifax, Hertford, Northampton and Martin Counties	N/A
Coastal Community Action, Inc.	Nonprofit	CAA	Carteret, Craven, Jones and Pamlico Counties	N/A
Community Action Opportunities, Inc.	Nonprofit	CAA	Buncombe, Madison and McDowell Counties	N/A
Davidson County Community Action, Inc.	Nonprofit	CAA	Davidson County	N/A
Eastern Carolina Human Services Agency, Inc.	Nonprofit	CAA	Duplin, New Hanover and Onslow Counties	N/A
Economic Improvement Council, Inc.	Nonprofit	CAA	Camden, Chowan, Currituck, Dare, Gates, Hyde, Pasquotank, Perquimans, Tyrrell and Washington Counties	N/A
Experiment in Self-Reliance, Inc.	Nonprofit	CAA	Forsyth County	N/A

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CSBG Eligible Entity	Public or Nonprofit	Type of Agency	Geographical Area Served	Brief Description of "Other"
Four Square Community Action, Inc.	Nonprofit	CAA	Cherokee, Clay, Graham, and Swain Counties	N/A
Franklin-Vance-Warren Opportunity, Inc.	Nonprofit	CAA	Franklin, Granville, Vance and Warren Counties	N/A
Gaston Community Action, Inc.	Nonprofit	CAA	Cleveland, Gaston, Lincoln and Stanly Counties	N/A
Greene Lamp, Inc.	Nonprofit	CAA	Beaufort, Greene, Lenoir and Pitt Counties	N/A
ICARE, Inc.	Nonprofit	CAA	Alexander and Iredell and Counties	N/A
Johnston-Lee-Harnett Community Action, Inc.	Nonprofit	CAA	Johnston, Lee and Harnett Counties	N/A
Macon Program for Progress	Nonprofit	CAA	Macon County	N/A
Mountain Projects, Inc.	Nonprofit	CAA	Haywood and Jackson Counties	N/A
Nash-Edgecombe Economic Development, Inc.	Nonprofit	CAA	Edgecombe, Nash, and Wilson Counties	N/A
Passage Home	Nonprofit	CAA	Wake County	N/A

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CSBG Eligible Entity	Public or Nonprofit	Type of Agency	Geographical Area Served	Brief Description of "Other"
Salisbury-Rowan Community Action Agency, Inc.	Nonprofit	CAA	Cabarrus and Rowan Counties	N/A
Sandhills Community Action Program, Inc.	Nonprofit	CAA	Anson, Montgomery, Moore and Richmond Counties	N/A
Southeastern Community & Family Services, Inc.	Nonprofit	CAA	Bladen, Brunswick, Hoke, Robeson, Columbus, Pender, and Scotland Counties	N/A
Telamon Corporation	Nonprofit	CAA	Caswell, Person and Rockingham	N/A
Union County Community Action, Inc.	Nonprofit	CAA	Union County	N/A
WAMY Community Action, Inc.	Nonprofit	CAA	Watauga, Avery, Mitchell, and Yancey Counties	N/A
Wayne Action Group for Economic Solvency, Inc.	Nonprofit	CAA	Wayne County	N/A

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CSBG Eligible Entity	Public or Nonprofit	Type of Agency	Geographical Area Served	Brief Description of "Other"
Welfare Reform Liaison Project, Inc.	Nonprofit	CAA	Guilford County	N/A
Western Carolina Community Action, Inc.	Nonprofit	CAA	Henderson, Transylvania and Polk Counties	N/A
Yadkin Valley Economic Development District, Inc.	Nonprofit	CAA	Davie, Stokes, Surry, and Yadkin Counties	N/A

5.2. Total number of CSBG eligible entities: 34

5.3. **Changes to Eligible Entities List:** Has the list of eligible entities under item 5.1 changed since the State's last State Plan submission? If yes, briefly describe the changes. ☑ Yes ☐ No

Martin County Community Action is no longer a designated eligible entity. The three counties (Beaufort, Pitt and Martin) previously designated to this entity are now designated to Green Lamp, Inc (Beaufort and Pitt Counties) and Choanoke Area Development Association, Inc (Martin County).

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SECTION 6
Organizational Standards for Eligible Entities

Note: Reference IM 138, *State Establishment of Organizational Standards for CSBG Eligible Entities*, for more information on Organizational Standards. Click HERE for IM 138.

6.1. **Choice of Standards:** Check the box that applies. If using alternative standards, a) attach the complete list of alternative organizational standards, b) describe the reasons for using alternative standards, and c) describe how the standards are at least as rigorous as the COE-developed standards.

☑ The State will use the CSBG Organizational Standards Center of Excellence (COE) organizational standards (as described in IM 138)

☐ The State will use an alternative set of organizational standards

6.2. If the State is using the COE-developed organizational standards, does the State propose making a minor modification to the standards, as described in IM 138? ☐ Yes ☑ No

6.2a. If yes was selected in item 6.2, describe the State's proposed minor modification to the COE-developed organizational standards, and provide a rationale. N/A

6.3. How will/has the State officially adopt(ed) organizational standards for eligible entities in the State in a manner consistent with the State's administrative procedures act? If "Other" is selected, provide a timeline and additional information, as necessary.

☐ Regulation
☐ Policy
☑ Contracts with eligible entities

☑ Other, describe: North Carolina released a Guidance Memorandum November 20, 2015 related to Organizational Standards. Guidance Memorandum serve as official communication from the Office of Economic Opportunity.

6.4. How will the State assess eligible entities against organizational standards, as described in IM 138?

☐ Peer-to-peer review (with validation by the State or State-authorized third party)
☑ Self-assessment (with validation by the State or State-authorized third party)
☐ Self-assessment/peer review with State risk analysis
☑ State-authorized third party validation
☑ Regular, on-site CSBG monitoring
☐ Other

6.4a. Describe the assessment process.

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The State will use the CSBG Organizational Standards Center of Excellence organizational standards and self-assessment documents released by the Community Action Partnership. Remote and onsite assessments will require eligible entities to complete a self-assessments supported with documentation to confirm what is reported. State staff and/ or a State-authorized third party will review the self-assessment with support documentation and agree or disagree with the self-assessment. In areas that eligible entities and State staff and/ or a State-authorized third party disagree, opportunity for additional document review and clarification will be provided. In areas determined as not met, State staff and/ or a State-authorized third party will work with eligible entities in meeting the technical assistance plan and quality improvement plan requirements put forth in IM-138. Assessments for eligible entities will be completed on an annual basis and the number of organizational standards not met as well as eligible entities moving from not met to meet will be tracked. A Guidance Memorandum related to organizational standards was released as official communication and support to eligible entities in North Carolina. The State Office will continue to seek and incorporate the feedback of eligible entities and the North Carolina Community Action Association surrounding the assessment and utilization of the organizational standards in effort of assuring it serves to strengthen the overall performance management framework of CSBG in North Carolina. Lastly, the State Office will continue to collaborate with the North Carolina Community Action Association in targeted areas to provide quality technical assistance and guidance pertaining to the organizational standards.

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6.5. Will the State make exceptions in applying the organizational standards for any eligible entities due to special circumstances or organizational characteristics, as described in IM 138?

☐ Yes ☑ No

6.5a. If yes was selected in item 6.5, list the specific eligible entities the State will exempt from meeting organizational standards, and provide a description and a justification for each exemption. N/A

6.6. **Performance Target:** What percentage of eligible entities in the State does the State expect will meet all the State-adopted organizational standards in the next year? 24%

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SECTION 7
State Use of Funds

Eligible Entity Allocation (90 Percent Funds) [Section 675C(a) of the CSBG Act]

7.1 Formula: Select the method (formula) that best describes the current practice for allocating CSBG funds to eligible entities.

Base + Formula

7.1a. Does the State statutory or regulatory authority specify the terms or formula for allocating the 90 percent funds among eligible entities? ☑ Yes ☐ No

7.2. Planned Allocation: Specify the planned allocation of 90 percent funds to eligible entities, as described under Section 675C(a) of the CSBG Act. The estimated allocations may be in dollars or percentages. For each eligible entity receiving funds, provide the Funding Amount in either dollars (columns 2 and 4) or percentage (columns 3 and 5) for the fiscal years covered by this plan.

Planned CSBG 90 Percent Funds		
CSBG Eligible Entity	Year One (SFY 2018-19)	Year Two (SFY 2019-20)
	Funding Amount	Funding Amount
Action Pathways, Inc.	$867,001*	$751,535
Alamance County Community Services Agency, Inc.	$263,212	$300,182
Blue Ridge Community Action, Inc.	$366,453*	$412,351
Blue Ridge Opportunity Commission, Inc.	$212,053*	$211,344
Catawba County Department of Social Services	$222,191*	$238,273
Central Piedmont Community Action	$1,040,606*	$1,028,304
Charlotte Area Fund	$1,740,232*	$1,506,058
Choanoke Area Development Association, Inc.	$318,303	$363,012
Coastal Community Action, Inc.	$282,548*	$289,783

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Planned CSBG 90 Percent Funds		
Community Action Opportunities, Inc.	$495,760*	$514,452
Davidson County Community Action, Inc.	$215,747*	$237,518
Eastern Carolina Human Services Agency, Inc.	$787,826*	$806,374
Economic Improvement Council, Inc.	$248,297*	$271,062
Experiment in Self-Reliance, Inc.	$683,378*	$671,567
Four Square Community Action, Inc.	$124,760*	$120,000
Franklin-Vance-Warren Opportunity, Inc.	$403,323*	$359,290
Gaston Community Action, Inc.	$710,504*	$783,622
Greene Lamp, Inc.	$723,217*	$732,070
ICARE, Inc.	$267,753	$305,361
Johnston-Lee-Harnett Community Action, Inc.	$538,380*	$578,253
Macon Program for Progress	$127,246*	$120,000
Mountain Projects, Inc.	$238,284*	$214,681
Nash-Edgecombe Economic Development, Inc.	$429,139	$489,415
Passage Home	$1,008,823	$1,150,520
Salisbury-Rowan Community Action Agency, Inc.	$579,181*	$459,592
Sandhills Community Action Program, Inc.	$337,595*	$373,380
Southeastern Community & Family Services, Inc.	$1,016,600*	$1,104,375
Telamon Corporation	$374,375*	$282,919
Union County Community Action, Inc.	$261,121*	$221,185
WAMY Community Action, Inc.	$322,809*	$318,826
Wayne Action Group for Economic Solvency, Inc.	$221,399*	$230,179

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Planned CSBG 90 Percent Funds		
Welfare Reform Liaison Project, Inc.	**$857,308***	**$814,396**
Western Carolina Community Action, Inc.	**$201,658**	**$229,982**
Yadkin Valley Economic Development District, Inc.	**$325,196***	**$322,417**
Total	**$16,812,278**	**$16,812,278**
*Note: Year One/ SFY 2018-19 allocations include anticipated agency specific carry-forward funding.		

7.3. Distribution Process: Describe the specific steps in the State's process for distributing 90 percent funds to the eligible entities and include the number of days each step is expected to take; include information about State legislative approval or other types of administrative approval (such as approval by a board or commission).

In compliance with the federal legislation, NC ensures that 90 percent of funds are made available to eligible entities through the Department of Health and Human Services contract process (90-120 days). The state outlines the requirement in its annual Community Services Block Grant Management Plan used for submission to the State's Budget Bill for legislative approval (90-120 days) and the requirement is specified in 10A NCAC 97C .0108 ALLOCATION OF CSBG FUNDS.

7.4. Distribution Timeframe: Does the State plan to make funds available to eligible entities no later than 30 calendar days after OCS distributes the Federal award? ☐ Yes ☑ No

7.4a. If no, describe State procedures to ensure funds are made available to eligible entities consistently and without interruption. While North Carolina does not make new funding available within 30 days after receipt of the federal award, there is no break in funding. No break in funding is supported through first in first out draw down and expenditure method in conjunction with issuing contracts on the state fiscal year calendar as opposed to the federal fiscal year calendar.

7.5. Performance Management Adjustment: How is the State improving grant and/or contract administration procedures under this State Plan as compared to past plans? Any improvements should be based on analysis of past performance, and should consider feedback from eligible entities, OCS, and other sources, such as the public hearing. If the State is not making any improvements, provide further detail.

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- The process for obligating carry-forward funds within two successive Federal Fiscal Years has been adjusted to increase contracting efficiency, support eligible entity planning and increase the ability of agencies to spend 100% of available resources.
- Application processes and tools will continue to be reviewed with the goal of decreasing errors and increasing efficiencies of the contracting process.

Administrative Funds [Section 675C(b)(2) of the CSBG Act]

7.6. What amount of State CSBG funds does the State plan to allocate for administrative activities, under this State Plan? The estimate may be in dollars or a percentage. 5%

7.7. How many State staff positions will be funded in whole or in part with CSBG funds under this State Plan? 10

7.8. How many State Full Time Equivalents (FTEs) will be funded with CSBG funds under this State Plan? 10

Remainder/Discretionary Funds [Section 675C(b) of the CSBG Act]

7.9. Does the State have remainder/discretionary funds? ☑ Yes ☐ No

If yes was selected, describe how the State plans to use remainder/discretionary funds in the table below.

Reference table on the following page

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Use of Remainder/Discretionary Funds					
Remainder/ Discretionary Fund Uses (See 675C(b)(1) of the CSBG Act)	**Year One (SFY 2018-19)**		**Year Two (SFY 2019-20)**		**Brief description of services/activities**
	Planned $	**Planned %**	**Planned $**	**Planned %**	
a. Training/technical assistance to eligible entities	**$233,504**	**25%**	**$280,205**	**30%**	Training/ Technical Assistance will focus on strengthening agency capacity, mitigating risk and compliance with organizational standards and accountability measures outlined in the Performance Management Framework
b. Coordination of State-operated programs and/or local programs					
c. Statewide coordination and communication among eligible entities	**$233,504**	**25%**	**$373,605**	**40%**	Funding will support outcome tracking and performance reporting at the local and state levels.
d. Analysis of distribution of CSBG funds to determine if targeting greatest need	**$74,721**	**8%**			The distribution method for the 5% discretionary and 90% eligible entity funding will be examined in conjunction with this assessment to inform funding methodology for maximizing allocations for poverty reduction.
e. Asset-building programs					

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f. Innovative programs/ activities by CAAs or other neighborhood groups (may include fatherhood and strengthening families initiatives)			**$280,205**	**30%**	The assessment of needs completed in Year 1 in conjunction with national performance management efforts and other relevant sources will be utilized to identify target areas for funding
g. State charity tax credits					
h. Other activities, specify: Limited Purpose Agencies (Affordable Housing Group of NC, NC Commission on Indian Affairs, Telamon Corporation, Western Economic Development Organization	**$392,286**	**42%**			Four Limited Purpose Agencies operating projects for a specific target population or specific program area will be funded with 42% of the discretionary allocation. The projects will target: American Indians, Workforce Preparation for ESOL population, Housing and Education. The North Carolina Administrative Code currently specifies this use for discretionary funding.
	$934,015	**100%**	**$934,015**	**100%**	
Note: all funding proposed above is dependent upon pending proposed changes within the NC Administrative Code.					

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7.10. What types of organizations, if any, does the State plan to work with (by grant or contract using remainder/discretionary funds) to carry out some or all of the activities in table 7.9.

Pending proposed changes to the North Carolina Administrative Code, discretionary funding will be awarded through a Request for Application process. As such, while all the organizations checked below could potentially receive funding, final awards and contracts will be dependent upon the application and selection process.

☑ CSBG eligible entities (if checked, include the expected number of CSBG eligible entities to receive funds)

☑ Other community-based organizations

☑ State Community Action association

☑ Regional CSBG technical assistance provider(s)

☑ National technical assistance provider(s)

☐ Individual consultant(s)
☐ Tribes and Tribal Organizations
☑ Other: Limited Purpose Agencies (non-eligible entity)

☐ None (the State will carry out activities directly)

7.11. Performance Management Adjustment: How is the State adjusting the use of remainder/discretionary funds under this State Plan as compared to past plans? Any adjustment should be based on the State's analysis of past performance, and should consider feedback from eligible entities, OCS, and other sources, such as the public hearing. If the State is not making any adjustments, provide further detail.

NC Division of Social Services Office of Economic Opportunity (OEO) is proposing amendments to the NC Administrative Code to support resources being made available consistent with federally authorized purposes. Pending amendment approval, additional resources will be made available for training and technical, statewide coordination and communication among eligible entities, analysis of distribution of CSBG funds and innovative programs/ activities. These are areas that discretionary funding has not previously been utilized for due to the NC Administrative Code requirements.

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SECTION 8
State Training and Technical Assistance

8.1. Describe the State's plan for delivering CSBG-funded training and technical assistance to eligible entities under this State Plan by completing the table below. Add a row for each activity: indicate the timeframe; whether it is training, technical assistance or both; and the topic. (CSBG funding used for this activity is referenced under item 7.9(a), Use of Remainder/Discretionary Funds.)

Note: 8.1 is associated with State Accountability Measure 3Sc and may pre-populate the State's annual report form.

Training and Technical Assistance		
FY Quarter	**Training, Technical Assistance, or Both**	**Category**
All quarters	• Both	• Other: State Office quarterly leadership conference call/ webinar with North Carolina's Community Action network. Topics are based on need. Purpose is to further strengthen relationships, give the network important guidance, address needs and allow agencies to identify concerns and/or successes. • Reporting: targeted T/TA for quarterly report submissions • ROMA: quarterly performance and expenditure reporting • ROMA: quarterly calls/ webinars for North Carolina's NCRTs
Ongoing / Multiple Quarters	• Both	• Organizational Standards – technical assistance for eligible entities with unmet standards • Monitoring
Q1	• Both	• Reporting: State Office works with eligible entities in cleaning the CSBG-IS/ Annual Report • ROMA: quarterly performance and expenditure reporting
Q2	• Both	• Community Assessment: CSBG Application • Fiscal: CSBG Application • Organizational Standards – General: CSBG Application
Q3	• Both	• Fiscal: NCCAA Annual Conference • Governance/Tripartite Boards: NCCAA Annual Conference • Organizational Standards – General: NCCAA Annual Conference • Communication: NCCAA Annual Conference • ROMA: NCCAA Annual Conference • Technology: NCCAA Annual Conference
Q4		• ROMA: year-end performance and expenditure reporting

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Training and Technical Assistance		
FY Quarter	**Training, Technical Assistance, or Both**	**Category**
Q5	• Both	• Reporting: State Office works with eligible entities in cleaning the CSBG-IS/ Annual Report • ROMA: quarterly performance and expenditure reporting
Q6	• Both	• Community Assessment: CSBG Application • Fiscal: CSBG Application • General: CSBG Application
Q7	• Both	• Fiscal: NCCAA Annual Conference • Governance/Tripartite Boards: NCCAA Annual Conference • Organizational Standards – General: NCCAA Annual Conference • Communication: NCCAA Annual Conference • ROMA: NCCAA Annual Conference • Technology: NCCAA Annual Conference • ROMA: year-end performance and expenditure reporting
Q8		• ROMA: year-end performance and expenditure reporting

8.1a. The planned budget for the training and technical assistance plan (as indicated in the Remainder/Discretionary Funds table in item 7.9): Y1: $233,504/ 25%

Y2: $280,205/ 30%

8.2. Does the State have in place Technical Assistance Plans (TAPs) or Quality Improvement Plans (QIPs) for all eligible entities with unmet organizational standards, if appropriate?

☐ Yes ☐ No

To be included upon submission

8.3. Indicate the types of organizations through which the State plans to provide training and/or technical assistance as described in item 8.1, and briefly describe their involvement? (Check all that apply.)

☑ CSBG eligible entities (if checked, provide the expected number of CSBG eligible entities to receive funds)

☐ Other community-based organizations

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- ☑ State Community Action association
- ☑ Regional CSBG technical assistance provider(s)
- ☑ National technical assistance provider(s)
- ☑ Individual consultant(s)
- ☐ Tribes and Tribal Organizations
- ☑ Other State Office

8.4. Performance Management Adjustment: How is the State adjusting the training and technical assistance plan under this State Plan as compared to past plans? Any adjustment should be based on the State's analysis of past performance, and should consider feedback from eligible entities, OCS, and other sources, such as the public hearing. If the State is not making any adjustments, provide further detail.

- NC Division of Social Services Office of Economic Opportunity (OEO) is completing the RPIC Combined Training and Technical Assistance Plan Template provided as part of the Organizational Standards Center of Excellence (OSCOE)
- Assessment of the NC CSBG Networks needs may include: feedback provided through the American Customer Satisfaction Index; Organizational Assessment Scores; On-site/ remote monitoring activities; responses to T/TA surveys; feedback received from agencies
- Pending NC Administrative Rule amendments, a portion of discretionary funding is being proposed for training and technical assistance to strengthen areas associated with the Performance Management Initiative
- Training and Technical assistance to support increased number of eligible entities meeting 100% of the Organizational Standards is a priority

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SECTION 9
State Linkages and Communication

9.1. **State Linkages and Coordination at the State Level:** Describe the linkages and coordination at the State level that the State plans to create or maintain to ensure increased access to CSBG services to low-income people and communities under this State Plan and avoid duplication of services (as required by the assurance under Section 676(b)(5)). Describe or attach additional information as needed. **[Check all that apply from the list below and provide a Narrative, 2500 Characters]**

- ☑ State Low Income Home Energy Assistance Program (LIHEAP) office
- ☑ State Weatherization office
- ☑ State Temporary Assistance for Needy Families (TANF) office
- ☑ State Head Start office
- ☐ State public health office
- ☐ State education department
- ☑ State Workforce Innovation and Opportunity Act (WIOA) agency
- ☐ State budget office
- ☑ Supplemental Nutrition Assistance Program (SNAP)
- ☑ State child welfare office
- ☐ State housing office
- ☐ Other

The State's CSBG Program is housed within the NC Department of Health and Human Services Division of Social Services Office of Economic Opportunity. It should be noted that Division also houses Child Support Enforcement, TANF (Workfirst), LIHEAP, Refugee Assistance, Food & Nutrition and other programs/services akin to scope of work for CSBG. As an area of special focus, CSBG will be working in collaboration with the redesign of the TANF program and the Department of Commerce's WIOA program through the Administration for Children and Families, Office of Family Assistance Systems to Family Stability National Policy Academy for the purpose of creating job-driven training approaches to build career pathways to obtain and maintain promising employment opportunities for low-income families.

9.2. **State Linkages and Coordination at the Local Level:** Describe the linkages and coordination at the local level that the State plans to create or maintain with governmental and other social services, especially antipoverty programs, to assure the

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effective delivery of and coordination of CSBG services to low-income people and communities and avoid duplication of services (as required by assurances under Sections 676(b)(5) and (b)(6)). Attach additional information as needed.

Each CSBG eligible entity collaborates and coordinates services at the local level based upon the needs and resources available within their respective service areas. The State Office collects this information in narrative format from each eligible entity through an annual application for funding. While each eligible entity is unique in its approach, some examples of common strategies for linkages and coordination created or maintained to increase CSBG services and avoid duplication include participation on local human service councils where representatives from human service agencies meet regularly to identify solutions to specific problems being experienced by low-income families, referrals with service providers addressing issues associated with poverty and collaborations with local Division of Social Services, Workforce Innovation and Opportunity Act providers, community colleges, local businesses, faith-based organizations, civic organizations and other non-profit agencies. Additionally, each eligible entity is responsible for incorporating the input of low-income families within the service area and tripartite board representatives to inform efforts related to provision of services and elimination of poverty barriers. The State Office will continue a targeted effort of strengthening the collaboration of CSBG eligible entities and local Division of Social Service Offices through coordination with the North Carolina Community Action Association and North Carolina Association of County Departments of Social Services. An increased effort will be placed on areas of potential collaboration with the North Carolina Department of Commerce as the lead state agency for the Workforce Innovation and Opportunity Act and the Temporary Assistance for Needy Families Program which is housed within the same organizational and physical location as CSBG.

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9.3. Eligible Entity Linkages and Coordination

9.3a State Assurance of Eligible Entity Linkages and Coordination: Describe how the State will assure that the eligible entities will coordinate and establish linkages to assure the effective delivery of and coordination of CSBG services to low-income people and communities and avoid duplication of services (as required by the assurance under Section 676(b)(5)). Attach additional information as needed.

The State Office provides ongoing communication to leadership within the North Carolina Community Action network through quarterly leadership webinars, North Carolina Community Action Association Council of Executive Director meetings and presentations on targeted areas. Additionally, the North Carolina Community Action Association holds regular regional meetings with agencies providing services within the same geographic region. These modes of communication present opportunities for the State Office, the State Association and Local Agencies to discuss and plan coordination among eligible entities.

9.3b State Assurance of Eligible Entity Linkages to Fill Service Gaps: Describe how the eligible entities will develop linkages to fill identified gaps in the services, through the provision of information, referrals, case management, and follow-up consultations, according to the assurance under Section 676(b)(3)(B) of the CSBG Act.

Each CSBG eligible entity develops linkages to fill identified gaps in the services, through the provision of information, referrals, case management and follow-up consultations based upon the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding. As part of the annual application process, each eligible entity completes a community needs assessment which informs targeting resources to fill identified gaps and avoid duplication of services. While each eligible entity is unique in its approach, the provision of services through a self-sufficiency case-management model which includes assessment, direct services, referrals and follow-up with each enrolled family is a common approach among eligible entities. Additionally, eligible entities collaborate with local public agencies, businesses, faith-based organizations, civic organizations and other non-profit organizations as a method to develop linkages to fill identified gaps and avoid duplication of services.

9.4. Workforce Innovation and Opportunity Act (WIOA) Employment and Training Activities: Does the State intend to include CSBG employment and training activities as part of a WIOA Combined State Plan, as allowed under the Workforce Innovation and Opportunity Act (as required by the assurance under Section 676(b)(5) of the CSBG Act)? ☑Yes

☐ No

9.4a If the State selected "yes" under item 9.4, provide the CSBG-specific information included in the State's WIOA Combined Plan. This information includes a description of how the State and the eligible entities will coordinate the provision of employment and training activities through statewide and local WIOA workforce development systems. This information may also include examples of innovative employment and training programs and activities conducted by community action agencies or other neighborhood-based organizations as part of a community antipoverty strategy. Upon defining expectations of CSBG being a required partner as outlined in the WIOA, North Carolina will engage in policy and practice initiatives on the state level to support employment training and one-stop career center service coordination at the local level.

9.4b. If the State selected "no" under item 9.4, describe the coordination of employment and training activities, as defined in Section 3 of WIOA, by the State and by eligible entities providing activities through the WIOA system. N/A

9.5. Emergency Energy Crisis Intervention: Describe how the State will assure, where appropriate, that emergency energy crisis intervention programs under title XXVI (relating to Low-Income Home Energy Assistance) are conducted in each community in the State, as required by the assurance under Section 676(b)(6) of the CSBG Act).

Each CSBG eligible entity supports and/ or operates emergency energy crisis intervention programs under title XXVI based upon the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding. While each eligible entity is unique in its approach, common approaches to supporting emergency energy crisis intervention is through operating Weatherization and Heating and Air Replacement and Repair Programs and referrals to appropriate providers. Application National Performance Indicators within the CSBG Annual Report and the state required outcome "the number of participant families provided emergency assistance" serve as information sources for the State to indicate emergency crisis services provided or referred by eligible entities.

9.6. State Assurance: Faith-based Organizations, Charitable Groups, Community Organizations: Describe how the State will assure local eligible entities will coordinate and form partnerships with other organizations, including faith-based organizations, charitable groups, and community organizations, according to the State's assurance under Section 676(b)(9) of the CSBG Act.

Each CSBG eligible entity coordinates and forms partnerships with other organizations, including faith-based organizations, charitable groups, and community organizations based upon the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding. While each eligible entity is unique in its approach, the

importance of the mission and established goals of agencies is a common driver for the coordination and formation of partnerships with other organizations. Eligible entities often strengthen coordination and partnerships through entities represented on the tripartite board of directors. The eligible entity capacity building section of the CSBG Annual Report will serve as an information source for the State to indicate eligible entities are coordinating services and partnering with other agencies to address the needs in their respective service areas.

9.7 Coordination of Eligible Entity 90 Percent Funds with Public/Private Resources: Describe how the eligible entities will coordinate CSBG 90 percent funds with other public and private resources, according to the assurance under Section 676(b)(3)(C) of the CSBG Act

Each CSBG eligible entity coordinates CSBG funds with other public and private resources based upon the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding. The public and private sectors of the tripartite boards serve as an important mechanism for the coordination of CSBG funds across these resources. While each eligible entity is unique in its approach, some examples of coordinating CSBG funds with other public and private resources include: coordination and collaboration with local Division of Social Services, Workforce Innovation and Opportunity Act providers, community colleges, local businesses, faith-based organizations, civic organizations, and other non-profit organizations. Module 2 of the CSBG Annual Report serve as information sources for the State to indicate public/ private resources mobilized by eligible entities as well as partnerships with such entities.

9.8. Coordination among Eligible Entities and State Community Action Association: Describe State activities for supporting coordination among the eligible entities and the State Community Action Association.

The State Office provides ongoing communication to leadership within the North Carolina Community Action network through quarterly leadership webinars, North Carolina Community Action Association Council of Executive Director meetings and presentations on targeted areas. Additionally, the North Carolina Community Action Agency holds regular regional meetings with agencies providing services within the same geographic region. These modes of communication present opportunities for the State Office, the State Association and Local Agencies to discuss and plan coordination among eligible entities.

9.9 Communication with Eligible Entities and the State Community Action Association: In the table below, describe the State's plan for communicating with eligible entities, the State Community Action Association, and other partners under this State Plan. Include communication about annual hearings and legislative hearings, as described under Section 4, CSBG Hearing Requirements.

Topic	Expected Frequency	Format	Brief Description of "Other"
Announcement for the public review and comment period.	Semi-Annually	Meetings/Presentation Website Email Other	Newspapers
NC Community Action Association Annual Conference	Annually	Meetings/Presentation	N/A
NC Office of Economic Opportunity Leadership calls	Quarterly	Meetings/Presentation	N/A
NC Office of Economic Opportunity quarterly performance and expenditure letters	Quarterly	Other	Office of Economic quarterly performance and expenditure letters.
NC Office of Economic Opportunity Director monthly update emails to the network Executive Directors	Monthly	E-mail	N/A
NC Office of Economic Opportunity staff present at the North Carolina Community Action Association's	Quarterly	Meetings/Presentation	N/A

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Topic	Expected Frequency	Format	Brief Description of "Other"
Council of Executive Director meetings.			
NC Office of Economic Opportunity staff communicate as needed with assigned agencies related to compliance, efficiency and effectiveness.	Other	Other	E-mails, letters, conference calls and/ or in-person visits are completed on an as needed basis
Webinar and/ or conference calls	Other	Meetings/Presentation	The State Office will provide, coordinate and/or support webinars and conference calls on an as needed bases for areas relating to compliance, training and technical assistance.
NC Office of Economic Opportunity provide guidance with formal communication in Guidance Memorandums	Other	Other	Guidance Memoranda are released as needed
NC Office of Economic Opportunity posts information to the website as needed.	Other	Website	As needed

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9.10. **Feedback to Eligible Entities and State Community Action Association:** Describe how the State will provide feedback to local entities and State Community Action Associations regarding performance on State Accountability Measures.

The State will provide feedback to local entities and the State Community Action Association on performance specific to the State Accountability Measures through quarterly and year end updates in narrative, presentation, listening sessions and/or meeting formats. In addition to the modes of communication detailed in 9.9, the State's CSBG and State Association Directors meet regularly to discuss overall strategies for strengthening resource coordination, service delivery and performance management for CSBG related activities. Regular and ongoing communications will support the states success with achieving positive results related to accountability measures in the area of state plan development, grantee monitoring and corrective action and organizational standards for eligible entities.

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9.11. Performance Management Adjustment: How is the State adjusting the Communication plan in this State Plan as compared to past plans? Any adjustment should be based on the State's analysis of past performance, and should consider feedback from eligible entities, OCS, and other sources, such as the public hearing. If the State is not making any adjustments, provide further detail.

- NC Division of Social Services Office of Economic Opportunity (OEO) is planning to increase remote and regional training opportunities for eligibility entities
- NC Division of Social Services Office of Economic Opportunity (OEO) is planning to increase the efficiency/ timeliness of written communications
- NC Division of Social Services Office of Economic Opportunity (OEO) is planning to strengthen collaborative efforts and communication with the NC Community Action Association surrounding eligible entity performance
- NC Division of Social Services Office of Economic Opportunity (OEO) will continue to have representation on the NC Performance Management Workgroup to support adjustments to communication where applicable

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SECTION 10
Monitoring, Corrective Action, and Fiscal Controls

Monitoring of Eligible Entities (Section 678B(a) of the CSBG Act)

10.1. Specify the proposed schedule for planned monitoring visits including: full on-site reviews; on-site reviews of newly designated entities; follow-up reviews – including return visits to entities that failed to meet State goals, standards, and requirements; and other reviews as appropriate.

This is an estimated schedule to assist States in planning. States may indicate "no review" for entities the State does not plan to monitor in the performance period.

For States that have a monitoring approach that does not fit within the table parameters, attach the State's proposed monitoring schedule.

CSBG Eligible Entity	Review Type	Target Date	Date of Last Full Onsite Review (if applicable)
Action Pathways, Inc.	Triennial	FY2 Q3 04/01/19-06/30/19	6/14-17/2016
Alamance County Community Services Agency, Inc.	Triennial	FY1 Q1 10/1/17-12/31/17	9/15-17/2014
Blue Ridge Community Action, Inc.	No review		10/24-27/2016
Blue Ridge Opportunity Commission, Inc.	Triennial	FY2 Q2 01/01/19-03/30/19	3/8-9/2016
Catawba County Department of Social Services	Triennial	FY2 Q3 04/01/19-06/30/19	5/4-5/2016
Central Piedmont Community Action	Triennial	FY2 Q4 07/01/19-09/30/19	08/01-05/2016

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CSBG Eligible Entity	Review Type	Target Date	Date of Last Full Onsite Review (if applicable)
Charlotte Area Fund	Triennial	FY2 Q4 7/01/19-09/30/19	8/9-10/2016
Choanoke Area Development Association, Inc.	Triennial	FY2 Q3 04/01/19-06/30/19	6/21-24/2016
Coastal Community Action, Inc.	Triennial	FY1 Q2 01/01/18-03/30/18	1/5-7/2015
Community Action Opportunities, Inc.	Triennial	FY2 Q3 04/01/19-06/30/19	6/27-30/2016
Davidson County Community Action, Inc.	Triennial	FY1 Q1 10/1/17-12/31/17	11/3-5/2014
Eastern Carolina Human Services Agency, Inc.	Triennial	FY1 Q3 04/01/18-06/30/18	6/1-5/2015
Economic Improvement Council, Inc.	Triennial	FY2 Q4 7/01/19-09/30/19	8/3- 8/6/2016
Experiment in Self-Reliance, Inc.	Triennial	FY2 Q4 7/01/19-09/30/19	7/18-21/2016
Four Square Community Action, Inc.	No review		12/7-9/2016

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CSBG Eligible Entity	Review Type	Target Date	Date of Last Full Onsite Review (if applicable)
Franklin-Vance-Warren Opportunity, Inc.	Triennial	FY2 Q1 10/1/18-12/31/18	12/14-16/2015
Gaston Community Action, Inc.	Triennial	FY1 Q1 10/1/17-12/31/17	4/22-24/2014
Greene Lamp, Inc.	Triennial	FY1 Q4 7/01/18-09/30/18	8/17-20/2015
ICARE, Inc.	Triennial	FY2 Q2 01/01/19-03/30/19	2/2-4/2016
Johnston Lee Harnett Community Action	Triennial	FY2 Q3 04/01/19-06/30/19	5/24-27/2016
Macon Program for Progress	Triennial	FY2 Q3 04/01/19-06/30/19	6/6-9/2016
Mountain Projects, Inc.	Triennial	FY2 Q4 7/01/19-09/30/19	8/15-18/2016
Nash-Edgecombe Economic Development, Inc.	Triennial	FY2 Q3 04/01/19-06/30/19	3/03-05/2016
Passage Home	Triennial	FY1 Q1 10/1/17-12/31/17	3/31/2014-4/4/2014
Salisbury-Rowan Community Action Agency, Inc.	Triennial	FY2 Q4 7/01/19-09/30/19	8/23-26/2016

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CSBG Eligible Entity	Review Type	Target Date	Date of Last Full Onsite Review (if applicable)
Sandhills Community Action Program, Inc.	Triennial	FY2 Q4 7/01/19-09/30/19	9/12-15/2016
Southeastern Community & Family Services, Inc.	Follow-up	FY1 Q1 10/1/17-12/31/17	8/16-19/2016
Telamon Corporation	New entity/ Triennial	FY1 Q1 10/1/17-12/31/17	
Union County Community Action, Inc.	Triennial	FY1 Q2 01/01/18-03/30/18	3/10-13/2015
WAMY Community Action, Inc.	Triennial	FY1 Q2 01/01/18-03/30/18	1/26-29/2015
Wayne Action Group for Economic Solvency, Inc.	Triennial	FY2 Q3 04/01/19-06/30/19	4/28 - 5/2/2016
Welfare Reform Liaison Project, Inc.	Triennial	FY1 Q1 10/1/17-12/31/17	5/12-15/2014
Western Carolina Community Action, Inc.	Triennial	FY2 Q4 7/01/19-09/30/19	7/12-15/2016
Yadkin Valley Economic Development District, Inc.	Triennial	FY1 Q1 10/1/17-12/31/17	12/8-11/2014

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10.2. Monitoring Policies: Provide a copy of State monitoring policies and procedures by attaching and/or providing a hyperlink.

https://www2.ncdhhs.gov/dss/Monitoring/

10.3. Initial Monitoring Reports: According to the State's procedures, by how many calendar days must the State disseminate initial monitoring reports to local entities? 90

Corrective Action, Termination and Reduction of Funding and Assurance Requirements (Section 678C of the Act)

10.4. Closing Findings: Are State procedures for addressing eligible entity findings/deficiencies, and the documenting of closure of findings included in the State monitoring protocols attached above?

Yes ☐ ☑ No

10.4a. If no, describe State procedures for addressing eligible entity findings/deficiencies, and the documenting of closure of findings. North Carolina is currently in the process of revamping its comprehensive monitoring plan to strengthen recently defined expectations as a result of National Performance Management framework. While the monitoring protocol for closure of findings is not yet included in the published monitoring plan, a corrective action process has been implemented for years. This process involves the incorporation of standardized Corrective Action Worksheets (CAW) which accompany any monitoring report with identified findings which identifies the finding, cause of the finding, required action and details the actions/steps to be taken to correct the finding, the responsible party(ies) and the date by which the action/step will be completed. Upon agency submission of the evidence the action/steps have been taken, the State Office reviews the documentation and/or conducts a follow-up visit to confirm implementation of the planned action/steps and issues a formal response indicating that additional documentation and/or action is needed or that the agency has addressed the finding, the finding is closed and no additional action is necessary. While the Board may have a role in the Corrective Action process, the completion of the CAW is handled at the Executive Director level of the agency.

In North Carolina, for the purpose of CSBG Administration, a finding is defined as any area of non-compliance with federal or state rules, contracts requirements, agency bylaws/policies/procedures, or binding source document. All findings require corrective action; however, all findings and/or corrective actions do not result in Quality Improvement Plans (QIPs). Quality Improvement Plans are to be initiated when an eligible entity's level of non-compliance results in suspension of funding and/or the threat of de-designation as a result of documented repeat findings, fraud, waste, abuse, lack of capacity to safeguard resources, inability to demonstrate outcomes achievement or failure to meet contract requirements. Like the CAWs, QIPs will accompany a formal notice to the agency of the areas of non-compliance/findings, causes of the non-compliance/findings, required actions and details the actions/steps to be taken to correct the ongoing and/or significant deficiencies, the responsible party(ies) and the date by

which the action/step must be completed. Upon agency submission of the evidence the action/steps have been taken, the State Office will review the documentation and/or conduct a follow-up visit to confirm implementation of the planned action/steps and issue a formal response indicating that additional documentation and/or action is needed or that the agency has successfully addressed the deficiencies thereby removing the threat of de-designation. Unlike the CAW, the QIP will require Board and Executive Level Staff engagement and acknowledgement along with a minimum of monthly technical assistance contact by phone, email, document submission/reporting and/or in person or onsite visits. Should the agency fail to address the deficiencies outlined in the QIP, the State will follow IM 116.

10.5. **Quality Improvement Plans (QIPs):** How many eligible entities are currently on Quality Improvement Plans? 0

10.6. **Reporting of QIPs:** Describe the State's process for reporting eligible entities on QIPs to the Office of Community Services within 30 calendar days of the State approving a QIP?

North Carolina will copy the Office of Community Services (OCS) on all formal notifications to agencies indicating the State is approving a Quality Improvement Plan. To expedite receipt, a scan of the formal notice will be emailed to the OCS. NC respectfully asks that OCS specify a lead QIP point of contact and a process by which receipt of notification will be formally acknowledged and feedback provided.

10.7. **Assurance on Funding Reduction or Termination:** Does the State assure, according to Section 676(b)(8), that "any eligible entity that received CSBG funding the previous fiscal year will not have its funding terminated or reduced below the proportional share of funding the entity received in the previous fiscal year unless, after providing notice and an opportunity for a hearing on the record, the State determines that cause exists for such termination or such reduction, subject to review by the Secretary as provided in Section 678C(b)."

☑ Yes ☐ No

Policies on Eligible Entity Designation, De-designation, and Re-designation

10.8. Does the State CSBG statute and/or regulations provide for the designation of new eligible entities?

☑ Yes ☐ No

10.8a. If yes, provide the citation(s) of the law and/or regulation. If no, describe State procedures for the designation of new eligible entities.

Requirements for designation of new eligible entities are specified in Title 10A North Carolina Administrative Code, Chapter 97C .0106 and are available at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 10A - Health and

Human Services\Chapter 97 - Economic Opportunity and have been attached to the OLDC System.

10.9. Does the State CSBG statute and/or regulations provide for de-designation of eligible entities?

☐

Yes ☑ No

10.9a. If yes, provide the citation(s) of the law and/or regulation. If no, describe State procedures for de-designation of new eligible entities.

When de-designation becomes necessary, the State references Title 10A North Carolina Administrative Code 97C Section .1300 "Grant Recipient Compliance Liability: Suspension: Termination." In addition, the State notifies the Office of Community Services on the necessary action, follows IM 116 as deemed appropriate and works diligently to designate a new provider as quickly as possible to minimize the break in service delivery to eligible low-income families.

10.10. Does the State CSBG statute and/or regulations specify a process the State CSBG agency must follow to re-designate an existing eligible entity? ☐ Yes ☑ No

10.10a. If yes, provide the citation(s) of the law and/or regulation. If no, describe State procedures for re-designation of existing eligible entities.

North Carolina does not re-designate an existing eligible entity. If an eligible entity is de-designated, then it ceases to be the provider for CSBG services and the grant agreement is terminated as outlined in Title 10A North Carolina Administrative Code 97C .1302. While its return as a new eligible entity is unlikely, it could only be the result of requirements for designation of new eligible entities as specified in Title 10A North Carolina Administrative Code, Chapter 97C .0106.

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Fiscal Controls and Audits and Cooperation Assurance

10.11. Fiscal Controls and Accounting: Describe how the State's fiscal controls and accounting procedures will a) permit preparation of the SF-425 Federal fiscal reports (FFR) and b) permit the tracing of expenditures adequate to ensure funds have been used appropriately under the block grant, as required by Block Grant regulations applicable to CSBG at 45 CFR 96.30(a).

The Department of Health and Human Services Office of the Controller Federal Grants and Financial Reporting Unit is responsible for the management, coordination and supervision of all federal fund accounting, financial reporting, financial analysis, and audit resolution relative to federal funds accounting and the coordination of the annual accrual process and preparation of the Comprehensive Annual Financial Report (CAFR) for the Department of Health and Human Services. (It should be noted that this office is currently undergoing significant restructuring and as such, responsibilities and sections are subject to change.) CSBG Expenditures are tracked through FRC 54. The submission of interim FFRs will be on a quarterly, semi-annual, or annual basis, as directed by the Federal agency. A final FFR shall be submitted at the completion of the award agreement. The following reporting period end dates shall be used for interim reports: 3/31, 6/30, 9/30, or 12/31. For final FFRs, the reporting period end date shall be the end date of the project or grant period. Quarterly and semi-annual interim reports shall be submitted no later than 30 days after the end of each reporting period. Annual reports shall be submitted no later than 90 days after the end of each reporting period. Final reports shall be submitted no later than 90 days after the project or grant period end date.

10.12. Single Audit Management Decisions: Describe State procedures for issuing management decisions for eligible entity single audits, as required by Block Grant regulations applicable to CSBG at 45 CFR 75.521. If these procedures are described in the State monitoring protocols attached under item 10.2, indicate the page number.

Issuing single audit management decisions for eligible entities is a function of the Department of Health and Human Services Office of the Controller Audit, Monitoring and Resolution Branch's (ARM) review of audit reports. It should be noted in North Carolina that:

1) Required reports and audits of agencies are submitted by the eligible entity into the online grants reporting system at www.ncgrants.gov as administered by the Office of State Budget and Management (OSBM).
    a. Within ten (10) business days of submission of the audit into the online www.NCGrants.gov system, the ARM conducts a desk review of the audit to determine if it was conducted in accordance with the required audit standards.
    b. If an audit does not meet the required standards, the ARM will reject the submitted report within the www.ncgrants.gov system. ARM will

prepare and issue an email noting the rejection of the audit and listing the required standards that were not met.

c. The entity is allowed no more than 90 calendar days from the date the email is received to submit a revised audit report that meets the required standards.

d. If the audit meets all other standards, but is missing a required corrective action plan, the ARM drafts and issues an email to the Grantee Contact of the nongovernmental entity, as noted in the www.NCGrants.gov system, requesting a corrective action plan. This email allows the non-governmental entity three (3) weeks from the date of the email to provide a corrective action plan.

2) If the required reports have not been received within the required six (6) month period or an audit and required reports have not been received within the required nine (9) month period, the www.NCGrants.gov system automatically includes the organization on the "Warning List" which identifies Grantee Legal Name, Tax ID, Grantee Fiscal Year End, Grantee Contact Name, Phone Number and Email Address, Granting Agency for the particular noncompliant report, Grant Title, Grant Number, Contract Number, Date of Noncompliance and Date Suspension of Funds will become effective. ARM will run and review the "Warning List" on a monthly basis and notify all DHHS grantee entities included on the list of their noncompliance and reiterate reporting requirements via electronic mail. If an entity remains noncompliant as identified on the "Warning List" for 60 days, the entity is automatically rolled onto the OSBM "Suspension of Funding" list (SOFL) with suspension of funding effective immediately. State agencies are prohibited from entering into new grant agreements with these entities and should withhold grant funds not yet disbursed until the grantee has been removed from the SOFL.

10.13. Assurance on Federal Investigations: Will the State "permit and cooperate with Federal investigations undertaken in accordance with Section 678D" of the CSBG Act, as required by the assurance under Section 676(b)(7) of the CSBG Act?

☑ Yes ☐ No

10.14. Performance Management Adjustment: How is the State adjusting monitoring procedures in this State Plan as compared to past plans? Any adjustment should be based on the State's analysis of past performance, and should consider feedback from eligible entities, OCS, and other sources, such as the public hearing. If this State is not making any adjustments, provide further detail.

- NC Division of Social Services Office of Economic Opportunity (OEO) is planning to increase the efficiency/ timeliness of written communications for monitoring
- NC Division of Social Services Office of Economic Opportunity (OEO) is planning to revamp its comprehensive monitoring plan to strengthen recently defined expectations as a result of National Performance Management framework. NC Division of Social

Services Office of Economic Opportunity (OEO) will work with NC eligible entities and the NC Community Action Association as appropriate with development and roll-out of changes with the monitoring procedures.

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SECTION 11
Eligible Entity Tripartite Board

11.1. Which of the following measures are taken to ensure that the State verifies CSBG Eligible Entities are meeting Tripartite Board requirements under Section 676B of the CSBG Act?

☐ Attend Board meetings
☑ Review copies of Board meeting minutes

☑ Track Board vacancies/composition

☑ Other

The State Office monitors board requirements by collecting board membership/ composition rosters, inclusive of committees, during the annual application process. Board member profile sheets are submitted to the Office as new members are seated. The process by which members are selected as well as engaged is assessed through review of board minutes, board member files and agency by-laws during onsite and desktop monitoring. Attempts are made to meet with board members during onsite monitoring visits or when requested.

11.2. How often does the State require eligible entities (which are not on TAPs or QIPs) to provide updates (e.g., copies of meeting minutes, vacancy alerts, changes to bylaws, low-income member selection process, etc.) regarding their Tripartite Boards?

☑ Annually

☐ Semiannually
☐ Quarterly
☐ Monthly
☑ Other Board member profile sheets are required to be submitted to the Office as new members are seated.

11.3. **Assurance on Eligible Entity Tripartite Board Representation:** Describe how the State will carry out the assurance under Section 676(b)(10) of the CSBG Act that the State will require eligible entities to have policies and procedures by which individuals or organizations can petition for adequate representation on an eligible entities' Tripartite Board.

North Carolina will ensure that eligible entities have the required petition process to afford individuals and organizations expressing a need for adequate representation on the tripartite board by reviewing each eligible entities by-laws, policies and/ or procedures through desktop and/or onsite monitoring. Guidance will be issued to ensure the process delineates at a minimum:

1) A format in which the petitioner will specify why he/she or the organization/group feels inadequately represented
2) A reasonable number of signatures needed for the petition to be considered based on a set of defined criteria related to the service area and poverty population
3) The procedures by which the petition will be received, reviewed, approved for seating and/or denied and how the petitioner will be notified of the results

11.4. Does the State permit public eligible entities to use, as an alternative to a Tripartite Board, "another mechanism specified by the State to assure decision-making and participation by low-income individuals in the development, planning, implementation, and evaluation of programs" as allowed under Section 676B(b)(2) of the CSBG Act.

☑ Yes ☐ No

11.4a. If yes, describe the mechanism used by public eligible entities as an alternative to a Tripartite Board. An advisory council meeting the tripartite requirements applicable to eligible entities is used as an alternative.

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Section 12
Individual and Community Income Eligibility Requirements

12.1. Required Income Eligibility: What is the income eligibility threshold for services in the State? **[Check one item below.]**

☐ 125% of the HHS poverty line
☑ X % of the HHS poverty line (fill in the threshold):100%

☐ Varies by eligible entity

12.1a. Describe any State policy and/or procedures for income eligibility, such as treatment of income and family/household composition.

Eligibility requirements for CSBG are specified in Title 10A North Carolina Administrative Code, Chapter 97C .0107 and are available at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 10A - Health and Human Services\Chapter 97 - Economic Opportunity and have been attached to the OLDC System. In addition, Guidance Memorandum 2012-2 provides additional information and is available at https://www2.ncdhhs.gov/oeo/csbg/2012/gm_2012-2.pdf

12.2. Income Eligibility for General/Short Term Services: For services with limited in-take procedures (where individual income verification is not possible or practical), how does the State ensure eligible entities generally verify income eligibility for services? An example of these services is emergency food assistance.

Per Guidance Memorandum 2012-2, NC Office of Economic Opportunity has determined it is reasonable to attempt to verify income for all CSBG participants. Where income verification outlined in the required self-declaration statement is not possible, the agency must maintain a document that captures why income was not verified. Where no income was received, the self-declaration should indicate $0 as the annual income to which the applicant attests.

12.3. Community-targeted Services: For services that provide a community-wide benefit (e.g., development of community assets/facilities, building partnerships with other organizations), how does the State ensure eligible entities' services target and benefit low-income communities?

North Carolina acknowledges that provision of services with community-wide benefits as described is an area for strengthening; however, through onsite and desktop monitoring, the State ensures that all CSBG services provided are to families meeting the income guidelines established which are 100% of the federal poverty guideline as outlined in state rules and the Quality Measures of each eligible entities contract. These families are the same for which eligible entities provide advocacy services to in their

local communities. We believe that encouraging formal partnership agreements outlining this focus will strengthen the ability to ensure such services target and benefit low-income communities.

SECTION 13

Results Oriented Management and Accountability (ROMA) System

13.1. ROMA Participation: In which performance measurement system will the State and all eligible entities participate, as required by Section 678E(a) of the CSBG Act and the assurance under Section 676(b)(12) of the CSBG Act? **[Check one]**

Note: This response will also link to the corresponding assurance, item 14.12.

☑ The Results Oriented Management and Accountability (ROMA) System

☐ Another performance management system that meets the requirements of section 678E(b) of the CSBG Act

☐ An alternative system for measuring performance and results

13.1a. If ROMA was selected in item 13.1, attach and/or describe the State's written policies, procedures, or guidance documents on ROMA.

The North Carolina State Office includes written guidance surrounding ROMA within the annual CSBG application. The expected range of 80% - 120% of targeted performance and expected expenditure rate of 100% is identified in all quarterly and year-end letters from the State office to eligible entities. In the event performance or expenditures are below expected levels, agencies are required to identify meaningful reasons and planned adjustments to bring these within the expected range. The State Office includes this information in the letters which are mailed to the board chairperson and executive director. Additional supports for ROMA include: thirty National Certified ROMA Trainers across the North Carolina network (one within the State Office and 3 within the Association), ongoing training and technical assistance for the CSBG-IS/ Annual Report and elements of ROMA within the Accountable Results for Community Action case management database. In collaboration with the State Office, the North Carolina Community Action Association leads NC ROMA efforts through coordination of training and technical assistance with the cohort of NCRTs within the state. This includes, but is not limited to, coordination of regional and agency ROMA trainings, quarterly webinars/ conference calls and an NC ROMA annual retreat for NCRTs. The North Carolina State Office will work with eligible entities and provide T/TA as needed to support the transition to the CSBG Annual Report.

13.1b. If ROMA was not selected in item 13.1, describe the system the State will use for performance measurement. N/A

13.2. Indicate and describe the outcome measures the State will use to measure eligible entity performance in promoting self-sufficiency, family stability, and community revitalization, as required under Section 676(b)(12) of the CSBG Act?

The State Office requires the CSBG-IS/ Annual report be completed annually. Additionally, all North Carolina eligible entities are required to report outcomes measures specific to CSBG funding on a quarterly basis. The most common outcomes reported by eligible entities include: The number of participant families served; The number of low-income participant families rising above the poverty level; The average change in the annual income per participant family experiencing a change; The number of participant families obtaining employment; The number of participant families who are employed and obtain better employment; The average wage rate of employed participant families; The number of jobs with medical benefits obtained; The number of participant families completing education/ training programs; The number of participant families securing standard housing; The number of participant families provided emergency assistance; The number of participant families provided employment supports; The number of participant families provided educational supports.

☐ CSBG National Performance Indicators (NPIs)
☑ NPIs and others

☐ Others

13.3. How does the State support the eligible entities in using the ROMA system (or alternative performance measurement system)?

North Carolina has 30 National Certified ROMA Trainers (1 within the State Office and 3 within the Association). The North Carolina Community Action Association leads efforts surrounding these individuals being available to the network for trainings. Elements and concepts of ROMA are consistently incorporated into training and technical assistance materials made available through the State Office and the Association. Some additional efforts the State Office engages in to support use of the ROMA system include written guidance surrounding ROMA in quarterly and year-end report communications, ongoing training and technical assistance for the CSBG-IS/ Annual Report and elements of ROMA within the Accountable Results for Community Action case management database. In collaboration with the State Office, the North Carolina Community Action Association leads NC ROMA efforts through coordination of training and technical assistance with the cohort of NCRTs within the state. This includes, but is not limited to, coordination of regional and agency ROMA trainings, quarterly webinars/ conference calls and an NC ROMA annual retreat for NCRTs, and coordination of the NC Performance Management Leadership Workgroup. At a minimum, the State Office will support these efforts

through input and support of time of state staff members who are NCRTs and serving on the National DATA Task Force.

13.4. **Eligible Entity Use of Data**: How is the State validating that the eligible entities are using data to improve service delivery?

The State Office has an expected performance range of 80% - 120% of targeted performance and expenditure rate of 100%. As part of the annual CSBG application process, State Office staff compares proposed performance targets with past performance and expenditure data for each eligible entity. In the event performance or expenditures are outside of the expected levels or there are other concerns, agencies are required to identify meaningful reason underlying this difference and planned adjustments to bring these within the expected range. Additionally, data collection tools, review and training and technical assistance provided by the State Office for the CSBG-IS/ Annual report serves as an important mechanism to validate the use of data. Lastly, on-site and desktop monitoring conducted by State staff includes review of various levels of data and a dialogue with eligible entities on how this data is collected, utilized, reported and how it supports the effectiveness and efficiency of service delivery.

Community Action Plans and Needs Assessments

13.5. Describe how the State will secure a Community Action Plan from each eligible entity, as a condition of receipt of CSBG funding by each entity, as required by Section 676(b)(11) of the CSBG Act.

The State Office requires each eligible entity submit a CSBG application for funding on an annual basis. Through the annual application process, agencies submit a Community Anti-Poverty Plan include a narrative section, an agency strategy for eliminating poverty (e.g. community needs assessment), work plan, budget and plan for monitoring, assessment and evaluation. Key sections of the North Carolina Administrative Code putting forth information on the Community Action Plan include, but may not be limited to: 10A North Carolina Administrative Code, Chapter 97C .0201, 97C .0203, 97C .0204, 97C .0205, 97C .0206, 97C .0207. These are available at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 10A - Health and Human Services\Chapter 97 - Economic Opportunity and have been attached to the OLDC System. The annual application for CSBG funding is made available on the State Office website http://www.ncdhhs.gov/oeo/

13.6. **State Assurance:** Describe how the State will assure that each eligible entity includes a community needs assessment for the community served (which may be coordinated with community needs assessments conducted by other programs) in each entity's Community Action Plan, as required by Section 676(b)(11) of the CSBG Act.

The State Office requires each eligible entity submit a CSBG application for funding on an annual basis. An agency strategy for eliminating poverty, OEO Form 210, is a required section of the annual application and serves to meet the requirement put forth in the CSBG Act. While OEO Form 210 is the primary tool used to assure the requirement is met, items within the narrative section of the application also provide important information surrounding needs assessment and coordination of services.

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SECTION 14

CSBG Programmatic Assurances and Information Narrative (Section 676(b) of the CSBG Act)

14.1 Use of Funds Supporting Local Activities

CSBG Services

14.1a. 676(b)(1)(A): Describe how the State will assure "that funds made available through grant or allotment will be used –

(A) to support activities that are designed to assist low-income families and individuals, including families and individuals receiving assistance under title IV of the Social Security Act, homeless families and individuals, migrant or seasonal farmworkers, and elderly low-income individuals and families, and a description of how such activities will enable the families and individuals--

(i) to remove obstacles and solve problems that block the achievement of self-sufficiency (particularly for families and individuals who are attempting to transition off a State program carried out under part A of title IV of the Social Security Act);

(ii) to secure and retain meaningful employment;

(iii) to attain an adequate education with particular attention toward improving literacy skills of the low-income families in the community, which may include family literacy initiatives;

(iv) to make better use of available income;

(v) to obtain and maintain adequate housing and a suitable living environment;

(vi) to obtain emergency assistance through loans, grants, or other means to meet immediate and urgent individual and family needs;

(vii) to achieve greater participation in the affairs of the communities involved, including the development of public and private grassroots partnerships with local law enforcement agencies, local housing authorities, private foundations, and other public and private partners to –

(I) document best practices based on successful grassroots intervention in urban areas, to develop methodologies for widespread replication; and

(II) strengthen and improve relationships with local law enforcement agencies, which may include participation in activities such as neighborhood or community policing efforts;

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Through the annual CSBG application process, each eligible entity submits a Community Anti-Poverty Plan inclusive of a narrative section, an agency strategy for eliminating poverty (e.g. community needs assessment), work plan, budget and plan for monitoring, assessment and evaluation. In turn, each CSBG eligible entity determines the use of CSBG funds at the local level based upon the needs and resources in their respective service areas. North Carolina outlines 8 eligible project models: Self-Sufficiency, Employment, Education, Nutrition, Housing, Income Management, Information and Referral and Emergency Assistance. The majority of eligible entities in North Carolina implement self-sufficiency programs consisting of a comprehensive service delivery system to assist individuals and families with moving from poverty to economic independence. These agencies provide an array of services to families within their agency or in partnership with other human service agencies. Head Start, Workforce Innovation and Opportunity Act, Weatherization and Section 8 Rental Assistance are among the federal programs operated by most North Carolina eligible entities. North Carolina eligible entities also operate federal/state funded projects inclusive of but not limited to employment, nutrition, youth development, senior services and housing.

The State Office requires all eligible entities to report contracted outcomes specific to CSBG funding on a quarterly basis. The most commonly contracted/ reported outcomes include: The number of participant families served; The number of low-income participant families rising above the poverty level; The average change in the annual income per participant family experiencing a change; The number of participant families obtaining employment; The number of participant families who are employed and obtain better employment; The average wage rate of employed participant families; The number of jobs with medical benefits obtained; The number of participant families completing education/ training programs; The number of participant families securing standard housing; The number of participant families provided emergency assistance; The number of participant families provided employment supports; The number of participant families provided educational supports.

In addition to the annual application process and state CSBG reporting, the CSBG-IS/ Annual report serves as an additional information source used by the State to confirm the support of areas indicated above.

Needs of Youth

14.1b. 676(b)(1)(B) Describe how the State will assure "that funds made available through grant or allotment will be used –

(B) to address the needs of youth in low-income communities through youth development programs that support the primary role of the family, give priority to the prevention of youth problems and crime, and promote increased community coordination and collaboration in meeting the needs of youth, and support development and expansion of innovative community-based youth development programs that have demonstrated success in preventing or reducing youth crime, such as--

(i) programs for the establishment of violence-free zones that would involve youth development and intervention models (such as models involving youth mediation, youth mentoring, life skills training, job creation, and entrepreneurship programs); and
(ii) after-school child care programs;

Eligible entities may opt to address the needs of youth in low-income communities based on

the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding process. While each eligible entity is unique in its approach, some examples of how eligible entities achieve this include administering or partnering programs such as WIA Youth, Head Start, afterschool, childcare and teen pregnancy. Additionally, programs and partnerships surrounding youth include efforts such as risk prevention, crime prevention, skill development, education and nutrition.

Coordination of Other Programs

14.1c. 676(b)(1)(C) Describe how the State will assure "that funds made available through grant or allotment will be used –

(C) to make more effective use of, and to coordinate with, other programs related to the purposes of this subtitle (including State welfare reform efforts)

Based upon the needs and resources in their respective service areas, each CSBG eligible entity is responsible for conducting activities that promote effectiveness and coordination with other programs related the purposes of CSBG. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding process. While each eligible entity is unique in its approach, the tripartite board structure supports coordination and input surrounding effectiveness. Common partners of eligible entities include: Division of Social Services, Workforce Innovation and Opportunity Act providers, community colleges, local businesses, faith-based organizations, civic organizations, and other non-profit organizations.

State Use of Discretionary Funds

14.2 676(b)(2) Describe "how the State intends to use discretionary funds made available from the remainder of the grant or allotment described in section 675C(b) in accordance with this subtitle, including a description of how the State will support innovative community and neighborhood-based initiatives related to the purposes of this subtitle."

Please reference items 7.9 and 7.10. No response is required for this item in the Online Date Collection System (ODLC).

Eligible Entity Service Delivery, Coordination, and Innovation

14.3. 676(b)(3) "Based on information provided by eligible entities in the State, a description of..."

Eligible Entity Service Delivery System

14.3a. 676(b)(3)(A) Describe "the service delivery system, for services provided or coordinated with funds made available through grants made under 675C(a), targeted to low-income individuals and families in communities within the State;

The CSBG Program service delivery system is currently composed of 34 eligible entities, and 4 Limited Purpose Agencies. There are 33 private non-profit eligible entities and one public agency. The 4 LPAs are funded with the discretionary allocation only and provide services to a specific population or service category. Note, Telamon Corporation receives discretionary funding as an LPA and as a designated eligible entity.

Most eligible entities implement a comprehensive service delivery system to assist individuals and families with moving from poverty to economic independence. These agencies provide an array of services to families within their agency or in partnership with other human service agencies. Head Start, Workforce Investment Act, Weatherization and Section 8 Rental Assistance are among the federal programs operated by most North Carolina eligible entities. Eligible entities also operate federal/state funded projects inclusive of but not limited to employment, nutrition, youth development, senior services and housing. Multi-county eligible entities operate with a central office and neighborhood centers located throughout the service area.

In-keeping with the National ROMA goals, North Carolina encourages eligible entities to embrace and execute a Self-Sufficiency (comprehensive case management) projects to better mobilize funding for direct services while also leveraging CSBG funds with other resources. While this approach may be different from how other states administer CSBG, North Carolina believes it affords us the ability to demonstrate 1) CSBG's effectiveness in moving families from poverty based on 100% of the Federal Poverty Guidelines to economic stability and into independence, 2) allows us to scale participants' progress from In-Crisis to Thriving to demonstrate incremental effectiveness, 3) provides agencies with an effective framework for creating meaningful collaborations and generating additional funding to further the agencies goals and 4) permits the usage of CSBG for direct services provision to participants not for administrative purposes only. Although this is currently the preferred approach in North Carolina, it should be noted that in addition to Self-Sufficiency, North Carolina's sub-grantee agencies have the flexibility to administer Employment, Housing, Education, Nutrition, Emergency Assistance, Information and Referral and Income Management projects with CSBG funding.

Eligible Entity Linkages – Approach to Filling Service Gaps

14.3b. 676(b)(3)(B) Describe "how linkages will be developed to fill identified gaps in the services, through the provision of information, referrals, case management, and follow-up consultations."

Please reference item 9.3b. No response is required for this item in the Online Date Collection System (ODLC).

Coordination of Eligible Entity Allocation 90 Percent Funds with Public/Private Resources

14.3c. 676(b)(3)(C) Describe how funds made available through grants made under 675C(a)will be coordinated with other public and private resources."

Please reference item 9.7. No response is required for this item in the Online Date Collection System (ODLC).

Eligible Entity Innovative Community and Neighborhood Initiatives, Including Fatherhood/Parental Responsibility

14.3d. 676(b)(3)(D) Describe "how the local entity will use the funds [made available under 675C(a)] to support innovative community and neighborhood-based initiatives related to the purposes of this subtitle, which may include fatherhood initiatives and other initiatives with the goal of strengthening families and encouraging parenting."

Note: The description above is about eligible entity use of 90 percent funds to support these initiatives. States may also support these types of activities at the local level using State remainder/discretionary funds, allowable under Section 675C(b)(1)(F). In this State Plan, the State indicates funds allocated for these activities under item 7.9(f).

Each CSBG eligible entity supports innovative community and neighborhood-based initiatives based upon the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding process. While each eligible entity is unique in its approach, some examples of support for innovative community and neighborhood-based initiatives include Head Start Programs supporting fatherhood initiatives and targeted collaborations with faith-based organizations, non-profit organizations and organized community groups.

Eligible Entity Emergency Food and Nutrition Services

14.4. 676(b)(4) Describe how the State will assure "that eligible entities in the State will provide, on an emergency basis, for the provision of such supplies and services, nutritious foods, and related services, as may be necessary to counteract conditions of starvation and malnutrition among low-income individuals."

Each CSBG eligible provides emergency supplies and services to counteract conditions of starvation and malnutrition based upon the needs and resources in their respective service areas. The State Office collects this information in narrative format from each CSBG eligible entity through an annual application for funding process. While each eligible entity is unique in its approach, eligible entities provide direct services to families in these areas and/ or assist families access such assistance through referrals or partnerships. Some strategies being utilized to assist families with emergency food needs include the operation of regional food banks, sponsoring supplemental food programs for seniors, and coordinating/sponsoring emergency food box/voucher programs.

State and Eligible Entity Coordination/linkages and Workforce Innovation and Opportunity Act Employment and Training Activities

14.5. 676(b)(5) Describe how the State will assure "that the State and eligible entities in the State will coordinate, and establish linkages between, governmental and other social services programs to assure the effective delivery of such services, and [describe] how the State and the eligible entities will coordinate the provision of employment and training activities, as defined in section 3 of the Workforce Innovation and Opportunity Act, in the State and in communities with entities providing activities through statewide and local workforce development systems under such Act."

Please reference items 9.1, 9.2, 9.3a, 9.4, 9.4a, and 9.4b. No response is required for this item in the Online Date Collection System (ODLC).

State Coordination/Linkages and Low-income Home Energy Assistance

14.6. 676(b)(6) Provide "an assurance that the State will ensure coordination between antipoverty programs in each community in the State, and ensure, where appropriate, that emergency energy crisis intervention programs under title XXVI (relating to low-income home energy assistance) are conducted in such community."

Please reference items 9.2 and 9.5. No response is required for this item in the Online Date Collection System (ODLC).

Federal Investigations

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14.7. 676(b)(7) Provide "an assurance that the State will permit and cooperate with Federal investigations undertaken in accordance with section 678D."

Please reference item 10.13. No response is required for this item in the Online Date Collection System (ODLC).

Funding Reduction or Termination

14.8. 676(b)(8) Provide "an assurance that any eligible entity in the State that received funding in the previous fiscal year through a community services block grant made under this subtitle will not have its funding terminated under this subtitle, or reduced below the proportional share of funding the entity received in the previous fiscal year unless, after providing notice and an opportunity for a hearing on the record, the State determines that cause exists for such termination or such reduction, subject to review by the Secretary as provided in section 678C(b)."

Please reference item 10.7. No response is required for this item in the Online Date Collection System (ODLC).

Coordination with Faith-based Organizations, Charitable Groups, Community Organizations

14.9. 676(b)(9) Describe how the State will assure "that the State and eligible entities in the State will, to the maximum extent possible, coordinate programs with and form partnerships with other organizations serving low-income residents of the communities and members of the groups served by the State, including religious organizations, charitable groups, and community organizations."

Please reference item 9.6. No response is required for this item in the Online Date Collection System (ODLC).

Eligible Entity Tripartite Board Representation

14.10. 676(b)(10) Describe how "the State will require each eligible entity in the State to establish procedures under which a low-income individual, community organization, or religious organization, or representative of low-income individuals that considers its organization, or low-income individuals, to be inadequately represented on the board (or other mechanism) of the eligible entity to petition for adequate representation."

Please reference item 11.3. No response is required for this item in the Online Date Collection System (ODLC).

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Eligible Entity Community Action Plans and Community Needs Assessments

14.11. 676(b)(11) Provide "an assurance that the State will secure from each eligible entity in the State, as a condition to receipt of funding by the entity through a community services block grant made under this subtitle for a program, a community action plan (which shall be submitted to the Secretary, at the request of the Secretary, with the State plan) that includes a community-needs assessment for the community served, which may be coordinated with community-needs assessments conducted for other programs."

Please reference items 13.5 and 13.6. No response is required for this item in the Online Date Collection System (ODLC).

State and Eligible Entity Performance Measurement: ROMA or Alternate system

14.12. 676(b)(12) Provide "an assurance that the State and all eligible entities in the State will, not later than fiscal year 2001, participate in the Results Oriented Management and Accountability System, another performance measure system for which the Secretary facilitated development pursuant to section 678E(b), or an alternative system for measuring performance and results that meets the requirements of that section, and [describe] outcome measures to be used to measure eligible entity performance in promoting self-sufficiency, family stability, and community revitalization."

Please reference items 13.1, 13.2, 13.3, and 13.4. No response is required for this item in the Online Date Collection System (ODLC).

Validation for CSBG Eligible Entity Programmatic Narrative Sections

14.13. 676(b)(13) Provide "information describing how the State will carry out the assurances described in this section."

No response is required for this item in the Online Date Collection System (ODLC) as the State provides information for each of the assurances directly in section 14 or in corresponding items throughout the State Plan.

☐ By checking this box, the State CSBG authorized official is certifying the assurances set out above.

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SECTION 15
Federal Certifications

The box after each certification must be checked by the State CSBG authorized official.

15.1 Lobbying

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in

accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

☐ By checking this box, the State CSBG authorized official is providing the certification set out above.

15.2 Drug-Free Workplace Requirements

This certification is required by the regulations implementing the Drug-Free Workplace Act of 1988: 45 CFR Part 76, Subpart, F. Sections 76.630(c) and (d)(2) and 76.645 (a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For the Department of Health and Human Services, the central point is: Division of Grants Management and Oversight, Office of Management and Acquisition, Department of Health and Human Services, Room 517-D, 200 Independence Avenue, SW Washington, DC 20201.

Certification Regarding Drug-Free Workplace Requirements (Instructions for Certification)

(1) By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

(2) The certification set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

(3) For grantees other than individuals, Alternate I applies.

(4) For grantees who are individuals, Alternate II applies.

(5) Workplaces under grants, for grantees other than individuals, need to be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.

(6) Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performers in concert halls or radio studios).

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(7) If the workplace identified to the agency changes during the performance of the grant, the grantee shall inform the agency of the change(s), if it previously identified the workplaces in question (see paragraph five).

(8) Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:

Controlled substance means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 CFR 1308.11 through 1308.15);

Conviction means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;

Criminal drug statute means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;

Employee means the employee of a grantee directly engaged in the performance of work under a grant, including: (i) All direct charge employees; (ii) All indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and, (iii) Temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

Certification Regarding Drug-Free Workplace Requirements

Alternate I. (Grantees Other Than Individuals)

The grantee certifies that it will or will continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about - -

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

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(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will - -

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing, within 10 calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted - -

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant:

Place of Performance (Street address, city, county, state, zip code) **[Narrative, 2500 characters]**

Check if there are workplaces on file that are not identified here.

Alternate II. (Grantees Who Are Individuals)

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(a) The grantee certifies that, as a condition of the grant, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in conducting any activity with the grant;

(b) If convicted of a criminal drug offense resulting from a violation occurring during the conduct of any grant activity, he or she will report the conviction, in writing, within 10 calendar days of the conviction, to every grant officer or other designee, unless the Federal agency designates a central point for the receipt of such notices. When notice is made to such a central point, it shall include the identification number(s) of each affected grant.

[55 FR 21690, 21702, May 25, 1990]

☐ By checking this box, the State CSBG authorized official is providing the certification set out above.

15.3 Debarment

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

Certification Regarding Debarment, Suspension, and Other Responsibility Matters - -

Primary Covered Transactions

Instructions for Certification

(1) By signing and submitting this proposal, the prospective primary participant is providing the certification set out below.

(2) The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

(3) The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

(4) The prospective primary participant shall provide immediate written notice to the department or agency to which this proposal is submitted if at any time the prospective

DRAFT

primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

(5) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.

(6) The prospective primary participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.

(7) The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusive-Lower Tier Covered Transaction," provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

(8) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

(9) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(10) Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

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Certification Regarding Debarment, Suspension, and Other Responsibility Matters - -

Primary Covered Transactions

(1) The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(b) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

(d) Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - - Lower Tier Covered Transactions

Instructions for Certification

(1) By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

(2) The certification in this clause is a material representation of fact upon which reliance was

(3) placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

(4) The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier

DRAFT

participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

(5) The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

(6) The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

(7) The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

(8) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

(9) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(10) Except for transactions authorized under paragraph five of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

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DRAFT

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - - Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

☐ By checking this box, the State CSBG authorized official is providing the certification set out above.

15.4 Environmental Tobacco Smoke

Public Law 103227, Part C Environmental Tobacco Smoke, also known as the Pro Children Act of 1994, requires that smoking not be permitted in any portion of any indoor routinely owned or leased or contracted for by an entity and used routinely or regularly for provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity by signing and submitting this application the applicant/grantee certifies that it will comply with the requirements of the Act.

The applicant/grantee further agrees that it will require the language of this certification be included in any subawards which contain provisions for the children's services and that all subgrantees shall certify accordingly.

☐ By checking this box, the State CSBG authorized official is providing the certification set out above.

Senate Committee On Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
SHARON C. GOODSON	NC COMMUNITY ACTION ASSOC.
NICHOLE KARIM	NAMI NC
Gloria Williams Wilson	NEED Inc Rocky Mount NC
Faye Macon-Parker	NEED, Inc., Rocky Mount, NC
Morgan Dunn	Walk West
Sheryl Andrews	Central Piedmont Community Action Inc.
Stefanie Clements	Action Pathways
Cassandra Brand	Action Pathways Inc.
Cynthia Wilson	Action Pathways, Inc.
Gloria Barnes	NEED, Inc. Rocky Mount, N.C.
Kathy Zinck	NEED Inc Rocky Mt NC
[illegible]	NEED Inc Rocky M NC
Rosilyn Lee	NEED Inc Rocky MT. NC
Krystina Dillard	NC Community Action Assoc.
Denver Hill	NC Community Action Assoc
Joel Groce	NC Community Action Assoc.
Christopher S. Moody	CADA, Inc.
Roy Moore	CADA, Inc.

Senate Committee On Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
William Bolduc	ACF, HHS, Washington DC.
Kenji Bunch	NCJOC
Lori Ann Harris	LHHA
Julia Adams Scheurich	Cook City GR.
Rachel Beaulieu	PBLaw
Susanna Khachaturyan	Student
	Boehringer Ingelheim
Stacie Rhew	Boehringer Ingelheim
A. Chase	KMA
J.W. JOYNER	NEW FRAME
Jarrett Burr	BURRCC
BRIAN LEWIS	NEW FRAME
Emily Adams	NCAPA
Sarah Wolfe	MWC
Susan R. DeJarnett	NCANP
Travis McEntyre	BRCA
Karen Harshman	Blue Ridge Community Action

Senate Committee On Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
[illegible]	CCA
[illegible]	[illegible]
[illegible]	[illegible]
Brevlager	CaroMont Health
[illegible]	UNC HCS
[illegible]	[illegible]
[illegible]	WakeMed
[illegible]	[illegible]
[illegible]	[illegible]
Mike Leighs	NCPC
Tracy Kimbrell	Parker Poe
Evelyn Contre	NC Medical Board
DOUG HERON	DUKE
LT McCrimmon	DHHS
Dodie Reefer	CCE
JOE LANIER	TSS
WILLIAM BURCHETTE	AARP
John Setchfield	AARP

Senate Committee On Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
JERRY COHEN	NM
Ben Pacific	DHHS
John DelFiorino	Brabakker + Assoc.
Phoebe Landon	MWC
Becki Gray	John Locke Foundation
Amanda Donovan	KTS
Ryan Newald	WM
BRIANA LEACH	BCA
BRIAN SCHAFFER	BLN
	American Wood Council
	American Wood Council
Carla Beal	Care 4 Carolina
	Parkinson Law
Callie Kotanek	KL6
Laura Ziperski	Senator Tillman
Joseph Umlauf	Senator Pate

7

Senate Committee On Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
DR. Irish Spencer	WRLP Inc. Guilford County
Joyce Peters	CSS
Keter D Dexter	—
Prosper Amponsah	UNC Medical School
Dr. Doug Oimoff	UNC M School of Medicine
Sue Ann Forrest	NCMS
Randall Gunther	UNC SOM
Brainard Burrus	UNC SOM
Monroe Wolf	UNC SOM
Madeline Treasure	UNC SOM
Adam Hunter	UNC School of Medicine
Benjamin Kaplan	UNC School of Medicine
Patrick Sweet	UNC School of Medicine
[illegible]	[illegible]
Courtney [illegible]	NP
TJ Bugee	NP
Rob Lamm	[illegible]
[illegible]	GA

Senate Committee On Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
[illegible]	LWVNC
Catherine Devlin	AARP
Alex Johnson	AARP

SPEAKER SIGN-UP SHEET

Senate Committee Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Cynthia Wilson	Action Pathways
Elaine Clements	Action Pathways
Cassandra Brand	Action Pathways
Gloria Williams Wilson	NEED Inc, Rocky Mt NC
SHARON C. GOODSON	NC COMMUNITY ACTION ASSOC.
RW. Travis McIntyre	Blue Ridge Community Actions.

SPEAKER SIGN-UP SHEET

Senate Committee Health Care

May 24, 2017 – Room 643 LOB – 10:00 AM

2 MIN EACH

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Cynthia Wilson	Action Pathways
Diotanse Clemonts	Action Pathways
Cassandra Brand	Action Pathways
Gloria Williams Wilson	NEED Inc. Rocky Mt NC
SHARON C. GOODSON	NC COMMUNITY ACTION ASSOC.
Travis McIntyre	Blue Ridge Community Actions.
Dr. Irish Spencer	WRLP - Guilford County
Karen Harchman	~~Blue~~ Blue Ridge Community Action

Senate Committee on Health Care
Wednesday, June 14, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00am on June 14, 2017, in Room 643 of the Legislative Office Building. Sixteen Senate members were present.

Senator Joyce Krawiec presided.

Senator Krawiec opened the meeting by welcoming everyone and recognizing the Senate Sergeants-at-Arms—Terry Emondson, Steve McKaig and Sham Patel. She also recognized the Senate Pages in attendance—Kristina Edwards of Wake County, Audrey Moone of Wake County, Elisabeth Heath of Beaufort County, Sierra Foster of Davie County, Abby Young of Durham County, and Sydney Lee of New Hanover County.

The first order of business was HB248. Senator Krawiec recognized Representative Presnell to explain the bill and answer questions from the committee. Senator Hise moved to amend the bill. Senator Krawiec recognized Senator Hise to explain the amendment. Senator Hise explained the amendment. The amendment was adopted. Senator Hise moved in favor of the bill. The motion carried and the amendment was rolled into a proposed committee substitute and received a favorable report.

The second order of business was HB243. Senator Krawiec recognized Senator J. Davis to explain the bill. Sen. Harrington moved to consider the proposed committee subsititue; the motion carried. Senator J. Davis explained the bill to the committee. Senator McGinnis was recognized to speak on the bill. Senator J. Davis was recognized to speak on the bill. Representative Murphy was recognized to speak on the bill. Senator Hise moved to amend the bill. Senator Hise was recognized to explain the amendment. Senator J. Davis was recognized to speak on the bill. Senator Harrington moved for adoption of the amendment. Senator Hise was recognized to answer questions from the committee. The amendment was adopted. The amendment was rolled into a proposed committee substitute. Senator Krawiec recognized Representative Murphy to answer questions from the committee. Dr. Steven Stelma was recognized to speak from the public on the bill. The bill was held for the next meeting.

The third order of business was HB403. Senator Hise moved that the committee consider the proposed committee substitute; the motion carried. The proposed committee substitute was adopted and held for the next meeting.

The meeting adjourned at 11:00 AM

Senator Joyce Krawiec
Presiding

Brian Mooney, Committee Clerk

Principal Clerk _____
Reading Clerk _____

Corrected #2: Addition of HB 403

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 14, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 248	Sunset CABHAs/OmbudsmanChanges/DHHS Study.	Representative Dobson Representative Presnell Representative White Representative Carney
HB 243	Strengthen Opioid Misuse Prevention (STOP)Act.	Representative Murphy Representative Davis Representative Malone Representative Horn
HB 403	Behavioral Health and Medicaid Modifications.	Representative Dollar Representative Lambeth Representative Dobson Representative White

HB 403 is for discussion only.

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

Senate Committee on Health Care
Wednesday, June 14, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 248	Sunset CABHAs/OmbudsmanChanges/DHHS Study.	Representative Dobson Representative Presnell Representative White Representative Carney
HB 243	Strengthen Opioid Misuse Prevention (STOP)Act.	Representative Murphy Representative Davis Representative Malone Representative Horn
HB 403	Behavioral Health and Medicaid Modifications. FOR DISCUSSION ONLY	Representative Dollar Representative Lambeth Representative Dobson Representative White

Presentations

Other Business

Adjournment

HOUSE BILL 248:
Support for Older Adults & DHHS Study.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 13, 2017
Introduced by:	Reps. Dobson, Presnell, White, Carney	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	Second Edition		

OVERVIEW: ***House Bill 248 does the following three things: 1) encourages the cochairs of the Joint Legislative Oversight Committee on Health and Human Services (Oversight Committee) to consider appointing a Subcommittee on Aging to ensure that the State is meeting the current and anticipated needs of older adults; 2) makes changes to the adult care home and nursing home community advisory committees and the duties of the Office of the State Long-Term Care Ombudsman Program that conform to federal changes; and 3) requires the Department of Health and Human Services to study Public Law 113-51, HIV Organ Policy Equity (HOPE) Act and the Final Safeguards and Research Criteria publication by the US Department of Health and Human Services and the National Institutes of Health to determine any necessary public health safeguards, regulations, and statutory changes and to submit findings and recommendations to the Oversight Committee on or before January 1, 2018. The bill would become effective when it becomes law.***

BILL ANALYSIS:

Section 1: Subcommittee on Aging – Under current law,[1] the cochairs of the Joint Legislative Oversight Committee on Health and Human Services (Oversight Committee) have authority to establish subcommittees for the purpose of examining issues relating to services provided by particular Divisions within the Department of Health and Human Services (DHHS). Currently North Carolina has a significant older adult population and the percentage of older adults is anticipated to increase in the coming years. Section 1(a) of HB 248 encourages the cochairs of the Oversight Committee to consider appointing a Subcommittee on Aging to determine the service needs of older adults and to make recommendations on how to address those needs. While conducting the study, the Subcommittee is urged to seek input from a variety of stakeholders and interest groups, specifically including: the Divisions of Aging and Adult Services and Social Services, DHHS; the NC Coalition on Aging; the Senior Tarheel Legislature; and the Governor's Advisory Council on Aging. Section 1(b) provides that if the Subcommittee is appointed, it shall submit to the Oversight Committee an interim report on or before March 1, 2018, and a final report on or before November 1, 2018.

Note: Senate Bill 257, v.7 (House Budget), Section 11D.3(a) and (b) contain identical content to that included in HB 248, Section 1(a) and (b).

Section 2: Office of State Long-Term Care Ombudsman Changes – The federal Older Americans Act authorized Long-Term Care Ombudsman Programs. North Carolina's Long-Term Care Ombudsman Program consists of an Office of the State Long-Term Care Ombudsman and Offices of the

[1] G.S. 120-208.2(d)

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Regional Long-Term Care Ombudsman housed in Area Agencies on Aging. Ombudsmen assist residents of long term care facilities in exercising their rights and attempt to resolve grievances between residents, families and facilities, in addition to other services for older adults and their families.[2] S.L. 2015-220, Section 2, made changes to the Long-Term Care Ombudsman Program to conform to federal changes. Section 2 of HB 248 makes additional amendments to conform to the federal changes. Section 2(a) of the bill amends the adult care home community advisory committee to provide that the committee members function as representatives of, and are accountable to, the Office of the State Long-Term Care Ombudsman. Section 2(b) amends the nursing home advisory committees in a similar manner. Both Section 2(a) and (b) provide that the training, certification, and designation is in accordance with 45 C.F.R. 1324.13(c)(2). Consistent with 45 C.F.R. 1324.11(e) and other similar provisions, Section 2(c) amends the duties of the Office of the State Long-Term Care Ombudsman Program to add the responsibility to designate, suspend, and remove the designation of volunteer representatives of the Office of the State Long-Term Care Ombudsman, including any community advisory committee appointees.

Section 3: DHHS Study HOPE Act Safeguard and Research Criteria – Section 3 of the bill would requires DHHS to examine P.L. 113-51 HIV Organ Policy Equity (HOPE) Act, and the Final Safeguards and Research Criteria for transplantation of HIV-positive donor organs in HIV-positive recipients, published by the US Department of Health and Human Services and National Institutes of Health. The DHHS is required to determine public health safeguards, regulations and statutory changes necessary for consideration by the General Assembly. On or before January 1, 2018, the DHHS is required to submit a report of findings and recommendations, including any necessary statutory changes to the Oversight Committee.

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

[2] 2015 NC State Long-Term Care Ombudsman Program 2015 Report

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 248

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

H248-ASH-16 [v.5]

Amends Title [YES]
Second Edition

Date _____,2017

Senator Hise

moves to amend the bill on page 1, lines 2-4 by rewriting the lines to read:
"AN ACT TO SUNSET CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES; TO MAKE CHANGES TO THE ADULT CARE HOME";

And on page 1, lines 13-34, by rewriting the lines to read:

"**SECTION 1.(a)** Session Law 2012-171 is repealed.

SECTION 1.(b) G.S. 108C-3(e)(3) is repealed.

SECTION 1. (c) G.S. 108C-3(g)(2) reads as rewritten:

"(2) Agencies providing behavioral health ~~services, excluding Critical Access Behavioral Health Agencies.~~services."

SECTION 1.(d) The Department of Health and Human Services, Division of Medical Assistance, shall submit a State Plan Amendment request to the Centers for Medicare and Medicaid Services to remove references to Critical Access Behavioral Health Agencies (CABHAs) and to make any other changes necessary to implement this Section.

SECTION 1.(e) Notwithstanding any other provision of law to the contrary, providers that are enrolled as a Critical Access Behavioral Health Agency as of the date of this act becomes law shall remain in the provider screening, enrollment, and revalidation categorical risk level of "moderate" for purposes of G.S. 108C-3 for 12 months from the date this act becomes law.";

And on page 1, line 35 by rewriting the line to read:

"**SECTION 2.(a)** G.S. 131D-31 reads as rewritten:".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 248:
Add CABHA Sunset & Make Conforming Changes.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 13, 2017
Introduced by:	Reps. Dobson, Presnell, White, Carney	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	Amendment to Second Edition H248-ASH-16		

OVERVIEW: Amendment H248-ASH-16 for HB 248 replaces Section 1 of the bill with language to sunset the Critical Access Behavioral Health Agencies (CABHAs) and to make conforming changes.

AMENDMENT ANALYSIS:

Section 1 of HB 248 currently recommends the Co-Chairs for the Joint Legislative Oversight Committee on Health and Human Services consider a Subcommittee on Aging. This language was included in the House Budget.

Amendment H248-ASH-16 removes the language currently contained in Section 1 of HB 248 and replaces it with language to sunset the Critical Access Behavioral Health Agencies (CABHAs). The long title of the bill is amended to reflect the content change.

As a result of changes in service delivery, services currently provided by CABHAs will be able to be provided by other service providers which may potentially increase beneficiaries' access to those services.

Section 1(a) of the amendment repeals Session Law 2012-171 which pertains solely to CABHAs and specifically lists the services each CABHA must provide and the staffing requirements.

Sections 1(b) and (c) remove references to "Critical Access Behavioral Health Agencies" in G.S. 108C-3(e)(3) and (g)(2) pertaining to Medicaid and Health Choice provider screening and enrollment.

Section 1(d) directs the Department of Health and Human Services, Division of Medical Assistance to submit a State Plan Amendment request to the Centers for Medicare and Medicaid Services to remove references to CABHAs.

Section 1(e) provides that notwithstanding any law to the contrary, providers enrolled as CABHAs as of the date of the act becomes law must remain in the provider screening, enrollment, and revalidation categorical risk level of "moderate" for 12 months from the date the act becomes law.

The final change contained in the amendment corrects a typo to change "written" to "rewritten" in the bill.

Karen Cochrane-Brown
Director

H248-SMSH-57-ASH-16-V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 248
Committee Substitute Favorable 4/19/17

Short Title: Support for Older Adults & DHHS Study. (Public)

Sponsors:

Referred to:

March 6, 2017

A BILL TO BE ENTITLED

AN ACT TO RECOMMEND THAT THE COCHAIRS FOR THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES CONSIDER A SUBCOMMITTEE ON AGING; TO MAKE CHANGES TO THE ADULT CARE HOME AND NURSING HOME ADVISORY COMMITTEES TO CONFORM TO THE ADMINISTRATION FOR COMMUNITY LIVING RULES AND RECENT CHANGES TO THE STATE LONG-TERM CARE OMBUDSMAN PROGRAM; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY THE HOPE ACT AND RELATED FEDERAL REGULATIONS AND TO MAKE RECOMMENDATIONS TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Pursuant to the authority in G.S. 120-208.2(d), the cochairs for the Joint Legislative Oversight Committee on Health and Human Services may consider appointing a Subcommittee on Aging to examine the State's delivery of services for older adults in order to (i) determine their service needs and to (ii) make recommendations to the Oversight Committee on how to address those needs. North Carolina currently ranks ninth in the nation for the size of the age 60 and older population and tenth in the nation for the age 85 and older population. From 2015 to 2035, the age 65 and older population is projected to increase sixty-seven percent (67%) and the age 85 and older population is projected to increase one hundred two percent (102%). By 2019, North Carolina will have more people that are 60 years of age and older than children age 0-17. It is recommended that the Subcommittee examine the range of programs and services for older adults throughout the continuum of care. The Subcommittee is encouraged to seek input from a variety of stakeholders and interest groups including: the Division of Aging and Adult Services and the Division of Social Services, Department of Health and Human Services; the North Carolina Coalition on Aging; the North Carolina Senior Tarheel Legislature, and the Governor's Advisory Council on Aging.

SECTION 1.(b) If a Subcommittee on Aging is appointed, the Subcommittee shall submit an interim report of its findings and recommendations, including any proposed legislation, to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2018, and shall submit a final report of its findings and recommendations, including any proposed legislation, on or before November 1, 2018, at which time it shall terminate unless reappointed by the cochairs of the Oversight Committee under the authority granted in G.S. 120-208.2(d).

SECTION 2.(a) G.S. 131D-31 reads as written:

"**§ 131D-31. Adult care home community advisory committees.**

(a) Statement of Purpose. – It is the intention of the General Assembly that community advisory ~~committees~~ committee members function as representatives of the Office of the State Long-Term Care Ombudsman and through their designation work to maintain the intent of the Adult Care Home Residents' Bill of Rights within the licensed adult care homes in this State. It is the further intent of the General Assembly that the committees promote community involvement and cooperation with adult care homes to ensure quality care for the elderly and disabled adults.

(b) Establishment and Appointment of Committees. –

(1) A community advisory committee shall be established in each county that has at least one licensed adult care home, shall serve all the homes in the county, and shall work with each of these homes for the best interests of the residents. In a county that has one, two, or three adult care homes with 10 or more beds, the committee shall have five members.

(2) In a county with four or more adult care homes with 10 or more beds, the committee shall have one additional member for each adult care home with 10 or more beds in excess of three, and may have up to five additional members at the discretion of the county commissioners, not to exceed a maximum of 25 members. In each county with four or more adult care homes with 10 or more beds, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each adult care home in the county. Each member must serve on at least one subcommittee.

(3) In counties with no adult care homes with 10 or more beds, the committee shall have five members. Regardless of how many members a particular community advisory committee is required to have, at least one member of each committee shall be a person involved in the area of mental retardation.

(4) The boards of county commissioners are encouraged to appoint the Adult Care Home Community Advisory Committees. Of the members, a minority (not less than one-third, but as close to one-third as possible) shall be chosen from among persons nominated by a majority of the chief administrators of adult care homes in the county. If the adult care home administrators fail to make a nomination within 45 days after written notification has been sent to them requesting a nomination, these appointments may be made without nominations. If the county commissioners fail to appoint members to a committee ~~by July 1, 1983,~~ the appointments shall be made by the ~~Assistant Secretary for Aging, Department of Health and Human Services,~~ Office of the State Long-Term Care Ombudsman no sooner than 45 days after nominations have been requested from the adult care home ~~administrators, but no later than October 1, 1983.~~administrators. In making appointments, the ~~Assistant Secretary for Aging~~ Office of the State Long-Term Care Ombudsman shall follow the same appointment process as that specified for the County Commissioners.

(5) Notwithstanding any other provision of this Article, appointment to an Adult Care Home Community Advisory Committee is contingent upon designation of the appointee by the Office of the State Long-Term Care Ombudsman in accordance with G.S. 143B-181.18. A designated appointee is directly accountable to the State Long-Term Care Ombudsman Program in order to perform the duties as a representative of the Office of the State Long-Term Care Ombudsman. Removal of the appointee's designation by the Office of the State Long-Term Care Ombudsman automatically rescinds the appointment to the Adult Care Home Community Advisory Committee.

(6) Any individual who serves as a community advisory committee member must go through the Office of the State Long-Term Care Ombudsman's certification and designation process and meet the certification and designation requirements in accordance with the State Long-Term Care Ombudsman Program Policies and Procedures.

(c) Joint Nursing and Adult Care Home Community Advisory Committees. – Appointment to the Nursing Home Community Advisory Committees shall preclude appointment to the Adult Care Home Community Advisory Committees except where written approval to combine these committees is obtained from the ~~Assistant Secretary for Aging, Department of Health and Human Services.~~Office of the State Long-Term Care Ombudsman. Where this approval is obtained, the Joint Nursing and Adult Care Home Community Advisory Committee shall have the membership required of Nursing Home Community Advisory Committees and one additional member for each adult care home with 10 or more beds licensed in the county. In counties with no adult care homes with 10 or more beds, there shall be one additional member for every four other types of adult care homes in the county. In no case shall the number of members on the Joint Nursing and Adult Care Home Community Advisory Committee exceed 25. Each member shall exercise the statutory rights and responsibilities of both Nursing Home Committees and Adult Care Home Committees. In making appointments to this joint committee, the county commissioners shall solicit nominations from both nursing and adult care home administrators for the appointment of approximately (but no more than) one-third of the members.

(d) Terms of Office. – Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a two-or three-year term at the county commissioners' discretion to ensure staggered terms of office.

(e) Vacancies. – Any vacancy shall be filled by appointment of a person for a one-year term. If this vacancy is in a position filled by an appointee nominated by the chief administrators of adult care homes within the county, then the county commissioners shall fill the vacancy from persons nominated by a majority of the chief administrators. If the adult care home administrators fail to make a nomination by registered mail within 45 days after written notification has been sent to them requesting a nomination, this appointment may be made without nominations. If the county commissioners fail to fill a vacancy, the vacancy shall ~~may~~ be filled by the Office of the State Long-Term Care Ombudsman ~~Assistant Secretary for Aging, Department of Health and Human Services~~ no sooner than 45 days after the commissioners have been notified of the appointment or vacancy.

(f) Officers. – The committee shall elect from its members a chair, to serve a one-year term.

(g) Minimum Qualifications for Appointment. – Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by the committee, or employee or governing board member of a home served by the committee, or immediate family member of a resident in a home served by the committee may be a member of that committee. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Office of the State Long-Term Care Ombudsman.~~Division of Aging, Department of Health and Human Services.~~

(h) Training, Certification and Designation. ~~Training.~~ The Office of the State Long-Term Care Ombudsman ~~Division of Aging, Department of Health and Human Services,~~ shall develop ~~training materials, which shall be distributed to each committee member.~~training requirements for certification and designation in accordance with 45 C.F.R. § 1324.13(c)(2).

Each committee member must receive certification training as specified by the State Long-Term Care Ombudsman Program Policies and Procedures and be designated as representatives of the State Long-Term Care Ombudsman Program ~~Division of Aging~~ prior to exercising any power under G.S. 131D-32. The State Long-Term Care Ombudsman Program ~~Division of Aging, Department of Health and Human Services,~~ shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.

(i) Any written communication made by a member of adult care home advisory committee within the course and scope of the member's duties, as specified in G.S. 131D-32, shall be privileged to the extent provided in this subsection. All communication shall be considered the property of the Office of the State Long-Term Care Ombudsman and subject to the Office's disclosure policies. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements and communications do not amount to intentional wrongdoing.

To the extent that any adult care home advisory committee or any member is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance."

SECTION 2.(b) G.S. 131E-128 reads as rewritten:

"**§ 131E-128. Nursing home advisory committees.**

(a) It is the purpose of the General Assembly that community advisory ~~committees~~ committee members function as representatives of the Office of the State Long-Term Care Ombudsman and through their designation work to maintain the intent of the Nursing Home Resident's Bill of Rights ~~this Part~~ within the nursing homes in this State, including nursing homes operated by hospitals licensed under Article 5 of G.S. Chapter 131E. It is the further purpose of the General Assembly that the committees promote community involvement and cooperation with nursing homes and an integration of these homes into a system of care for the elderly.

(b) (1) A community advisory committee shall be established in each county which has a nursing home, including a nursing home operated by a hospital licensed under Article 5 of G.S. Chapter 131E, shall serve all the homes in the county, and shall work with each home in the best interest of the persons residing in each home. In a county which has one, two, or three nursing homes, the committee shall have five members. In a county with four or more nursing homes, the committee shall have one additional member for each nursing home in excess of three, and may have up to five additional members per committee at the discretion of the county commissioners.

(2) In each county with four or more nursing homes, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each nursing home in the county. Each member must serve on at least one subcommittee.

(3) Boards of county commissioners are encouraged to appoint the Nursing Home Community Advisory Committees. ~~Each committee shall be appointed by the board of county commissioners.~~ Of the members, a minority (not less than one-third, but as close to one-third as possible) must be chosen from among persons nominated by a majority of the chief administrators of nursing homes in the county and of the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes. If the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to make a nomination within 45 days after written notification has been sent to them by the board of county commissioners

requesting a nomination, these appointments may be made by the board of county commissioners without nominations.

(4) Notwithstanding any other provision of this Article, appointment to a nursing home community advisory committee is contingent upon designation of the appointee by the Office of the State Long-Term Care Ombudsman in accordance with G.S. 143B-181.18. A designated appointee is directly accountable to the State Long-Term Care Ombudsman Program in order to perform the duties as a representative of the Office of the State Long-Term Care Ombudsman. Removal of the appointee's designation by the Office of the State Long-Term Care Ombudsman automatically rescinds the appointment to the nursing home community advisory committee.

(5) Any individual who serves as a community advisory committee member must go through the Office of the State Long-Term Care Ombudsman's certification and designation process and meet the certification and designation requirements in accordance with the State Long-Term Care Ombudsman Program Policies and Procedures.

(c) Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a three-year term. Persons who were originally nominees of nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, or who were appointed by the board of county commissioners when the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make nominations, may not be reappointed without the consent of a majority of the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes within the county. If the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to approve or reject the reappointment within 45 days of being requested by the board of county commissioners, the commissioners may reappoint the member if they so choose.

(d) Any vacancy shall be filled by appointment of a person for a one-year term. Any person replacing a member nominated by the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes or a person appointed when the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make a nomination shall be selected from among persons nominated by the administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, as provided in subsection (b). If the county commissioners fail to appoint members to a committee, or fail to fill a vacancy, the appointment shall ~~may~~ be made or vacancy filled by the Office of the State Long-Term Care Ombudsman ~~Secretary or the Secretary's designee~~ no sooner than 45 days after the commissioners have been notified of the appointment or vacancy if nomination or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is not required. If nominations or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is required, the appointment shall ~~may~~ be made or vacancy filled by the Office of the State Long-Term Care Ombudsman ~~Secretary or the Secretary's designee~~ no sooner than 45 days after the commissioners have received the nomination or approval, or no sooner than 45 days after the 45-day period for action by the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes.

(e) The committee shall elect from its members a chair, to serve a one-year term.

(f) Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by a committee, or employee or governing board member or immediate family member of an employee or governing board member of a home served by a committee, or immediate family member of a patient in a home served by a committee may be a member of a committee. Membership on a committee shall not be considered an office as defined in G.S. 128-1 or G.S. 128-1.1. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for the amount of actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Office of the State Long-Term Care Ombudsman, ~~Division of Aging,~~ which shall supply a copy to the Division of Health Service Regulation.

(g) The Office of the State Long-Term Care Ombudsman ~~Division of Aging, Department of Health and Human Services,~~ shall develop training ~~materials which shall be distributed to each committee member and nursing home.~~ requirements for certification and designation in accordance with 45 C.F.R. § 1324.13(c)(2). Each committee member must receive certification training as specified by the State Long-Term Care Ombudsman Program Policies and Procedures and be designated as representatives of the State Long-Term Care Ombudsman Program ~~Division of Aging~~ prior to exercising any power under subsection (h) of this section. The State Long-Term Care Ombudsman Program ~~Division of Aging, Department of Health and Human Services,~~ shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.

(h) (1) Each committee shall apprise itself of the general conditions under which the persons are residing in the homes, and shall work for the best interests of the persons in the homes. This may include assisting persons who have grievances with the home and facilitating the resolution of grievances at the local level.

(2) Each committee shall quarterly visit the nursing home it serves. For each official quarterly visit, a majority of the committee members shall be present. In addition, each committee may visit the nursing home it serves whenever it deems it necessary to carry out its duties. In counties with four or more nursing homes, the subcommittee assigned to a home shall perform the duties of the committee under this subdivision, and a majority of the subcommittee members must be present for any visit.

(3) Each member of a committee shall have the right ~~between 10:00 A.M. and 8:00 P.M.~~ to enter into the facility the committee serves in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited to homes served by those subcommittees to which the member has been appointed.

(4) The committee or subcommittee may communicate through its chair with the Department or any other agency in relation to the interest of any patient. The identity of any complainant or resident involved in a complaint shall not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq.

(5) Each home shall cooperate with the committee as it carries out its duties.

(6) Before entering into any nursing home, the committee, subcommittee, or member shall identify itself to the person present at the facility who is in charge of the facility at that time.

(i) Any written communication made by a member of a nursing home advisory committee within the course and scope of the member's duties, as specified in G.S. 131E-128, shall be privileged to the extent provided in this subsection. All communication shall be considered the property of the Office of the State Long-Term Care Ombudsman and subject to the Office's disclosure policies. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements or communications do not amount to intentional wrongdoing.

To the extent that any nursing home advisory committee or any member thereof is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance."

SECTION 2.(c) G.S. 143B-181.18 reads as rewritten:

"**§ 143B-181.18. Office of State Long-Term Care Ombudsman Program/State Ombudsman duties.**

The State Ombudsman shall perform 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.

(2) Supervise the State Long-Term Care Ombudsman Program pursuant to rules adopted by the Secretary of the Department of Health and Human Services pursuant to G.S. 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.

(3a) Designate certified Regional Ombudsmen as representatives of the Office of the State Long-Term Care Ombudsman ~~Office~~ as well as refuse, suspend, or remove designation as a representative of the Office of the State Long-Term Care Ombudsman in accordance with the ~~Office of the~~ State Long-Term Care Ombudsman Program Policies and Procedures.

(3b) Designate and refuse, suspend, or remove designation of volunteer representatives of the Office of the State Long-Term Care Ombudsman, including any community advisory committee appointees, in accordance with the State Long-Term Care Ombudsman Program 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.

(5) Provide training and technical assistance to regional ombudsmen.

(6) Establish procedures for appropriate access by regional ombudsmen to long-term care facilities and residents' files, records, and other information, including procedures to protect the confidentiality of these files, 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.

(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.

(9) Prepare findings regarding public education and community involvement efforts and innovative programs being provided in long-term care 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 as required by 42 U.S.C. § 3001 et seq. and regulations promulgated thereunder."

SECTION 3. The Department of Health and Human Services shall examine Public Law 113-51, HIV Organ Policy Equity (HOPE) Act, and the Final Safeguards and Research Criteria publication by the U.S. Department of Health and Human Services and National Institutes of Health to determine public health safeguards, regulations, and statutory changes necessary for consideration by the General Assembly. The Department shall submit a report of findings and recommendations, including any necessary statutory changes, to the Joint Legislative Oversight Committee on Health and Human Services on or before January 1, 2018.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 248

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

H248-ASH-16 [v.5]

Amends Title [YES]
Second Edition

Date 6-14-17 ,2017

Senator Hise

moves to amend the bill on page 1, lines 2-4 by rewriting the lines to read:
"AN ACT TO SUNSET CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES; TO MAKE CHANGES TO THE ADULT CARE HOME";

And on page 1, lines 13-34, by rewriting the lines to read:
"**SECTION 1.(a)** Session Law 2012-171 is repealed.
SECTION 1.(b) G.S. 108C-3(e)(3) is repealed.
SECTION 1. (c) G.S. 108C-3(g)(2) reads as rewritten:
"(2) Agencies providing behavioral health ~~services, excluding Critical Access Behavioral Health Agencies.~~services."
SECTION 1.(d) The Department of Health and Human Services, Division of Medical Assistance, shall submit a State Plan Amendment request to the Centers for Medicare and Medicaid Services to remove references to Critical Access Behavioral Health Agencies (CABHAs) and to make any other changes necessary to implement this Section.
SECTION 1.(e) Notwithstanding any other provision of law to the contrary, providers that are enrolled as a Critical Access Behavioral Health Agency as of the date of this act becomes law shall remain in the provider screening, enrollment, and revalidation categorical risk level of "moderate" for purposes of G.S. 108C-3 for 12 months from the date this act becomes law.";

And on page 1, line 35 by rewriting the line to read:
"**SECTION 2.(a)** G.S. 131D-31 reads as rewritten:".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED 6/14/17 FAILED _____ TABLED _____

H248-ASH-16-V-5

HOUSE BILL 243:
Strengthen Opioid Misuse Prevention (STOP)Act.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 14, 2017
Introduced by:	Reps. Murphy, Davis, Malone, Horn	**Prepared by:**	Augustus D. Willis
Analysis of:	PCS to Third Edition H243-CSTY-16		Committee Counsel

OVERVIEW: House Bill 243 would (i) extend the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (ii) designate certain Schedule II and III drugs as "targeted controlled substances and make changes to the laws governing the prescribing of those targeted controlled substances, (iii) clarify the allowable funds for syringe exchange programs, (iv) make changes to the statutes governing the Controlled Substance Reporting System (CSRS) database, and (v) amend language in the 2015 budget to facilitate the interstate connectivity of the CSRS database.

BILL ANALYSIS:

Part I. TITLE OF ACT

Section 1 sets forth the title of the act as the Strengthen Opioid Misuse Prevention (STOP) Act of 2017.

Part II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

G.S. 90-12.7 sets forth statutes governing the prescribing of opioid antagonists for treatment of a drug overdose. These statutes allow a practitioner to, either directly or by standing order, prescribe an opioid antagonist to a person at risk of experiencing an opiate-related overdose, or their family member, friend, or other person in a position to assist such a person. In 2016, the General Assembly expanded this to allow the State Health Director to issue prescriptions to such persons by way of a statewide standing order.

Section 2 would amend the statutes on the treatment of overdoses with opioid antagonist to (1) allow the State Health Director to name a designee to prescribe an opioid antagonist by statewide standing order, and (2) allow practitioners to either directly, or by standing order, prescribe an opioid antagonist to any governmental or nongovernmental organization for the purpose of distribution to persons at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist such a person. Any organization distributing the opioid antagonist would be required to include with it basic instruction and information on how to administer it.

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

Current law authorizes licensed physician assistants and nurse practitioners to write prescriptions so long as a supervising physician has provided written instructions for prescribing drugs and a written policy for periodic review by the physician of drugs prescribed.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Absent an emergency situation, the dispensing of Schedule II controlled substances generally requires a written prescription, made out no more than 6 months prior to the date the substance is dispensed, with an exception that no prescription is needed if the substance is dispensed directly by a practitioner to an ultimate user. Prescriptions for Schedule II controlled substances may not be refilled. Schedule III and IV controlled substances require a prescription no older than 6 months old and may not be refilled more than five times after the date of the prescription.

Section 3 would define the new term "targeted controlled substance" to include certain controlled substances currently included in Schedule II and Schedule III of the Controlled Substances Act.

Section 4 would amend the statutes authorizing physician assistants to write prescriptions by requiring a physician assistant to consult with the supervising physician prior to prescribing controlled substances included in the newly defined term "targeted controlled substance" if the therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant must consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.

Section 5 would amend the statutes authorizing nurse practitioners to write prescriptions by including the same requirements in Section 4.

Section 6 would require electronic prescriptions for all controlled substances included in the newly defined term "targeted controlled substance" unless the prescription is issued by:

- A practitioner who is dispensing directly to an ultimate user.
- A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis center or residential care facility.
- A practitioner who experiences temporary technological or electrical failure, or other extenuating circumstance that prevents the prescription from being transmitted electronically and the reason for this exception is documented in the patient's medical record.
- A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property and the reason for this exception is documented in the patient's medical record.

Prescriptions for targeted controlled substances would be limited to no more than a 5 day supply upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief immediately following a surgical procedure, in which case the practitioner may not prescribe more than a 7-day supply. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. The terms "acute pain," "chronic pain," and "surgical procedure" are defined. Dispensers are not required to verify that a practitioner falls within one of the exceptions from the requirement that all targeted controlled substances be e-prescribed and dispensers may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws. Dispensers are further immune from civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of G.S. 90-106.

Section 7 would require any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in the patient's home to provide oral and written information to the patient and the patient's family regarding the proper disposal of the controlled substance.

PART IV: CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

Section 8 would clarify language in the statute authorizing needle and syringe exchange programs to prohibit the use of State funds to purchase needles, hypodermic syringes, or other injection supplies. Non-State public funds could still be used for this purpose.

PART V: STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

The Controlled Substances Reporting System (CSRS) is a database maintained by the Department of Health and Human Services that tracks prescriptions for Schedule II through V controlled substances. Dispensers are required to report certain information on prescriptions they fill within 3 days after the prescription is delivered, but are encouraged to report such information within 24 hours. Such information is confidential and may only be accessed by certain persons for specific purposes set forth by statute. Under current law, veterinarians are not considered to be a "dispenser" for purposes of CSRS reporting requirements.

Section 9 would remove the exemption from the definition of "dispenser" for veterinarians, subjecting them to CSRS reporting requirements, define the term "pharmacy" as a person or entity who holds a valid pharmacy permit, and make other technical changes to the definitions used in the CSRS laws.

Section 10 would require dispensers to report required information by the close of the next business day after filling a prescription unless the system is temporarily not operational and the inability to report is documented in the dispenser's records. Section 10 also updates the information dispensers are required to report to include an address and telephone number for the owner of the animal in the case of a prescription dispensed for an animal. The Department of Health and Human Services would be required to assess civil penalties of up to $100 for a first violation, up to $250 for a second violation, and up to $500 for each subsequent violation, not to exceed $5,000 per pharmacy in a calendar year to pharmacies found to have failed to report required information within a reasonable period of time after being informed that such information is missing or incomplete. The PCS clarifies that pharmacies who, in good faith, attempt to report, will not be assessed a civil penalty.

Section 11 would amend the laws governing the confidentiality of CSRS data to allow the Department to notify practitioners and their respective licensing boards of prescribing behavior that increases risk of diversion of controlled substances, increases risk of harm to the patient, or is an outlier among other practitioner behavior. The PCS adds to Section 11 a requirement that the administrator of a hospital emergency department or hospital acute care facility provide the Department with lists of delegates who are authorized to receive data on behalf of providers within the facility. The lists must be submitted to the Department by December 1 of the calendar year preceding the year in which the delegation is to occur, however the lists may be updated at any time throughout the year. The Department has one week from the time it receives a list to establish the necessary delegate accounts within the CSRS.

Section 12 would add the following new sections to Article 5E of Chapter 90 of the General Statutes governing the CSRS:

- 90-113.74B: would require recipients of new or renewed pharmacist licenses to demonstrate to the NC Board of Pharmacy registration for access to the CSRS within 30 days of licensure.
- 90-113.74C: would require practitioners to review a patient's 12-month history in the CSRS prior to prescribing "targeted controlled substance" and review the patient's 12-month history in the CSRS every three months while the targeted controlled substance remains part of the patient's medical care plan. These reviews would have to be documented in the patient's medical records, along with the occasion of any CSRS outage that prevents such a review; the practitioner would be required to review the 12-month history upon restoration of the CSRS after an outage. In addition, a practitioner would be able to, but not required to, review a patient's CSRS history if: (1) the controlled substance is to be administered to the patient in a health care setting, hospital,

nursing home, outpatient dialysis facility, or residential care facility; (2) the controlled substance is for the treatment of cancer or a cancer-associated condition; or (3) the controlled substance is prescribed to a patient in hospice or palliative care. The Department would be required to conduct periodic audits of the review of the CSRS by prescribers and report to the appropriate licensing board any prescriber found to be in violation.

- 90-113.74D: would require a dispenser to review an individual's 12-month history in the CSRS prior to dispensing a targeted controlled substance whenever: 1) the dispenser believes the individual is seeking controlled substances for reasons other than treatment of a medical condition; 2) the prescriber is located outside of the usual area the dispenser serves; 3) the individual lives outside the usual area the dispenser serves; 4) the individual pays with cash when there is an insurance plan on file with the dispenser; or 5) the individual demonstrates potential misuse of a controlled substance. A dispenser would be required to withhold delivery of a prescription until verified if the dispenser believes it to be duplicative or fraudulent. Dispensers would be immune from civil or criminal liability for actions authorized by this section and failure to review the system prior to dispensing a controlled substance would not constitute medical negligence.
- 90-113.75A: would create a special revenue fund in DHHS for use in administering the CSRS.
- 90-113.75B: would require DHHS to make annual reports starting February 1, 2019, to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy. The reports would be required to include specified data on targeted controlled substances reported to the CSRS database during the preceding calendar year.

Section 13 would amend language from the 2015 budget to direct the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to continue working toward establishing interstate connectivity for the CSRS system.

EFFECTIVE DATE: Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 would become effective July 1, 2017. The new subsections of G.S. 90-106 dealing with e-prescribing in Section 6 would become effective January 1, 2020. The new subsections of G.S. 90-106 establishing limits on initial prescriptions for acute pain in Section 6 would become effective January 1, 2018. The portion of Section 12 creating the new statutes G.S. 90-113.75A through G.S. 90-113.75C would become effective September 1, 2017. The portion of Section 10 updating the information required to be reported to the CSRS database by dispensers becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the CSRS database has the capability to record the information required. The remainder of the act would become effective when it becomes law and would apply to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the CSRS database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 243
Committee Substitute Favorable 3/30/17
Third Edition Engrossed 4/10/17
PROPOSED SENATE COMMITTEE SUBSTITUTE H243-CSTY-16 [v.15]
06/12/2017 9:00:29 AM

Short Title: Strengthen Opioid Misuse Prevention (STOP)Act. (Public)

Sponsors:

Referred to:

March 6, 2017

A BILL TO BE ENTITLED

AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE CERTAIN SCHEDULE II OR III CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; REQUIRING HOSPICE AND PALLIATIVE CARE PROVIDERS TO PROVIDE EDUCATION REGARDING PROPER DISPOSAL OF CERTAIN UNUSED CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS; MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; AND REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS.

Whereas, the General Assembly recognizes the substantial impact the nationwide opioid epidemic continues to have on the State of North Carolina; and

Whereas, North Carolina has seen a 442 percent increase in overdose deaths caused by commonly prescribed opioids between 1999 and 2015; and

Whereas, the General Assembly fully recognizes the appropriate use of opioids in the treatment of acute and chronic pain; Now, therefore

The General Assembly of North Carolina enacts:

PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"**§ 90-12.7. 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:

a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

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:

1. A family member, friend, or other person.

2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director or a designee may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(3) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the 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.

(c) A pharmacist may dispense an opioid antagonist to a person ~~described in subdivision (b)(1) of this section~~ or organization pursuant to a prescription issued ~~pursuant to~~ 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.

(c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section 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. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.

(d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) 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.

(e) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.

(3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.

(4) The State Health Director acting pursuant to subsection (b) of this section.

(5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-87 reads as rewritten:

"**§ 90-87. Definitions.**

As used in this Article:

...

(26a) "Targeted controlled substance" means any controlled substance included in G.S. 90-90(1) or (2) or G.S. 90-91(d).

...."

SECTION 4. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every

90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 6. G.S. 90-106 reads as rewritten:

"**§ 90-106. Prescriptions and labeling.**

(a) ~~Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner.~~ No Schedule II substance shall be dispensed pursuant to a written or electronic prescription more than six months after the date it was prescribed.

(a1) Electronic Prescription Required; Exceptions. – Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all targeted controlled substances. This subsection does not apply to prescriptions for targeted controlled substances issued by any of the following:

(1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.

(2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis facility, or residential care facility as defined in G.S. 14-32.2.

(3) A practitioner who experiences temporary technological or electrical failure or other extenuating circumstance that prevents the prescription from being transmitted electronically, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(4) A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(a2) Verification by Dispenser Not Required. – A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a targeted controlled substance. A dispenser may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.

(a3) Limitation on Prescriptions Upon Initial Consultation for Acute Pain. – A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance for post-operative acute pain relief immediately following a surgical procedure. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E of the General Statutes, hospice facility, or residential care facility as defined in G.S. 14-32.2(c1). A practitioner who acts in accordance with the limitation on prescriptions as set forth in this subsection shall be immune from any civil liability or disciplinary action from the practitioner's occupational licensing agency for acting in accordance with this subsection.

(a4) Definitions. – As used in this subsection, the following terms have the following meanings:

(1) Acute pain. – Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

(2) Chronic pain. – Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(3) Surgical procedure. – A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

(a5) Dispenser Immunity. – A dispenser shall be immune from any civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of this section.

(b) In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.

(c) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.

(d) No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.

(e) No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.

(f) No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.

(g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.

(h) A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

(i) A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 7. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.**

Any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall, at the commencement of treatment, provide oral and written information

to the patient and his or her family regarding the proper disposal of such targeted controlled substances. This information shall include the availability of permanent drop boxes or periodic "drug take-back" events that allow for the safe disposal of controlled substances such as those permanent drop boxes and events that may be identified through North Carolina Operation Medicine Drop."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

"(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No ~~public~~ State funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

SECTION 9. G.S. 90-113.72 reads as rewritten:

"**§ 90-113.72. Definitions.**

The following definitions apply in this Article:

(1) ~~"Commission" means the~~ Commission. – The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(2) ~~"Controlled substance" means a~~ Controlled substance. – A controlled substance as defined in G.S. 90-87(5).

(3) ~~"Department" means the~~ Department. – The Department of Health and Human Services.

(4) ~~"Dispenser" means a~~ Dispenser. – A person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:

a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

b. Repealed by Session Laws 2013-152, s. 1, effective January 1, 2014, and applicable to prescriptions delivered on or after that date.

c. A wholesale distributor of a Schedule II through V controlled substance.

~~d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.~~

(4a) Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A.

(5) ~~"Ultimate user" means a~~ Ultimate user. – A person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the person's own use, for the use of a member of the person's household, or for the use of an animal owned or controlled by the person or by a member of the person's household."

SECTION 10. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting ~~system.~~system; civil penalties for failure to properly report.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser who is unable to submit prescription

information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than ~~the close of business three business days after the day when the prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hours~~the close of the next business day after the prescription is delivered; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system. In the event the dispenser is unable to report the information within the time frame required by this section because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the dispenser's records. Once the electrical or technological failure has been resolved, the dispenser shall promptly report the information.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.

(2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:

a. Full address, including city, state, and zip code,

b. Telephone number, and

c. Date of birth.

(2a) If the controlled substance is dispensed for an animal, the following information:

a. Name of the animal,

b. Full address, including city, state, and zip code of the owner of the animal, and

c. Telephone number of the owner of the animal.

(3) The date the prescription was written.

(4) The date the prescription was filled.

(5) The prescription number.

(6) Whether the prescription is new or a refill.

(7) Metric quantity of the dispensed drug.

(8) Estimated days of supply of dispensed drug, if provided to the dispenser.

(9) National Drug Code of dispensed drug.

(10) Prescriber's DEA number.

(11) Method of payment for the prescription.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than one hundred dollars ($100.00) for a first violation, two hundred fifty dollars ($250.00) for a second violation, and five hundred dollars

($500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of five thousand dollars ($5,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. A pharmacy acting in good faith that attempts to report the information required by this section shall not be assessed any civil penalty. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74 reads as rewritten:

"...

(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:

...

(1a) Notify practitioners and their respective licensing boards of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

...

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

(1) Persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients. A person authorized to receive data pursuant to this paragraph may delegate the authority to receive the data to other persons working under his or her direction and supervision, provided the Department approves this delegation.

a. The administrator of a hospital emergency department or hospital acute care facility shall provide the Department with a list of prescribers who are authorized to prescribe controlled substances for the purpose of providing medical care for patients of the hospital emergency department or hospital acute care facility and a list of delegates who are authorized to receive data on behalf of the providers listed. The administrator acting under this paragraph shall submit the lists to the Department no later than December 1 of the calendar year preceding the year during which the delegates are to receive data and may provide updated lists at any time during the course of the year. Within one week of receiving the initial or updated lists described in this paragraph, the Department shall establish all of the delegate accounts necessary to enable each delegate listed by the administrator of the hospital emergency department or hospital acute care facility to receive data on behalf of the listed prescribers. Delegations made pursuant to this paragraph are valid during the calendar year for which submitted by the administrator.

..."

SECTION 12. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"**§ 90-113.74B. Mandatory dispenser registration for access to controlled substances reporting system; exception.**

(a) Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he

or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

(b) This section does not apply to a licensee employed in a pharmacy practice setting where a Schedule II, III, or IV controlled substance will not be dispensed.

"**§ 90-113.74C. Practitioner use of controlled substances reporting system; mandatory reporting of violations.**

(a) Prior to initially prescribing a targeted controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the targeted controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the targeted controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient and the review shall be documented in the patient's medical record.

(b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a targeted controlled substance to the patient in any of the following circumstances:

(1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, outpatient dialysis facility, or residential care facility as defined in G.S. 14-32.2.

(2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.

(3) The controlled substance is prescribed to a patient in hospice care or palliative care.

(c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

"**§ 90-113.74D. Dispenser use of controlled substances reporting system.**

(a) Prior to dispensing a targeted controlled substance, a dispenser shall review the information in the controlled substances reporting system pertaining to the patient for the preceding 12-month period and document this review under any of the following circumstances:

(1) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user's existing medical condition.

(2) The prescriber is located outside of the usual geographic area served by the dispenser.

(3) The ultimate user resides outside of the usual geographic area served by the dispenser.

(4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser.

(5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following:

a. Over-utilization of the controlled substance.

b. Requests for early refills.

c. Utilization of multiple prescribers.

d. An appearance of being overly sedated or intoxicated upon presenting a prescription.

e. A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks.

(b) If a dispenser has reason to believe a prescription for a targeted controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate.

(c) A dispenser shall be immune from any civil or criminal liability for actions authorized by this section. Failure to review the system in accordance with subsection (a) of this section shall not constitute medical negligence.

"**§ 90-113.75A. Creation of Controlled Substances Reporting System Fund.**

(a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.

(b) The Fund shall consist of the following:

(1) Any moneys appropriated to the Fund by the General Assembly.

(2) Any moneys received from State, federal, private, or other sources for deposit into the Fund.

(c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"**§ 90-113.75B. Annual report to General Assembly and licensing boards.**

Annually on February 1, beginning February 1, 2019, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about targeted controlled substances reported to the system during the preceding calendar year:

(1) The total number of prescriptions dispensed, broken down by Schedule.

(2) Demographics about the ultimate users to whom prescriptions were dispensed.

(3) Statistics regarding the number of pills dispensed per prescription.

(4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.

(5) The number of ultimate users to whom a prescription was dispensed in more than one county.

(6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors, surgeons, palliative care practitioners, oncologists and other practitioners specializing in oncology, pain management practitioners, practitioners who specialize in hematology, including the treatment of sickle cell disease, and practitioners who

specialize in treating substance use disorder shall be treated as distinct categories of practitioners.

(7) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

SECTION 13.(a) Section 12F.16(h) of Session Law 2015-241 reads as rewritten:

"**SECTION 12F.16.(h)** ~~DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect. The Department shall request forty thousand thirty-five dollars ($40,035) to establish the initial interface for PMP InterConnect and thirty thousand dollars ($30,000) for two years of ongoing service, maintenance, and support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.~~The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System established under G.S. 90-113.73."

SECTION 13.(b) Section 12F.16(i)(3) of Session Law 2015-241 reads as rewritten:

"(3) ~~For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to establish the initial interface for PMP InterConnect, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.~~The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System established under G.S. 90-113.73."

PART VI. EFFECTIVE DATE

SECTION 14.(a) Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 of this act become effective July 1, 2017.

SECTION 14.(b) Subsections (a), (a1), and (a2) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2020.

SECTION 14.(c) Subsections (a3) and (a4) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2018.

SECTION 14.(d) G.S. 90-113.75A and G.S. 90-113.75B, as enacted by Section 12 of this act, become effective September 1, 2017.

SECTION 14.(e) Subsection (b) of G.S. 90-113.73(b), as enacted by Section 10 of this act, is effective when it becomes law. The remainder of Section 10 of this act becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the Controlled Substance Reporting System (CSRS) database has the capability to record the information described in Section 10 of this act. The Chief Information Officer shall notify the Revisor of Statutes once the CSRS database has the capability to record the information described in Section 10 of this act.

SECTION 14.(f) The remainder of this act is effective when it becomes law and applies to acts committed 30 days after the date the State Chief Information Officer notifies the

Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 243*

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

H243-ATY-31 [v.1]

Amends Title [NO]
H243-CSTY-16[v.15]

Date _____,2017

Senator Hise

moves to amend the bill on page 3, lines 33-42 by rewriting the lines to read:

"(5) A physician assistant shall personally consult with the supervising physician prior to prescribing a targeted controlled substance as defined in Article 5 of this Chapter when all of the following conditions apply:

a. The patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services.

b. The therapeutic use of the targeted controlled substance will, or is expected to exceed a period of 30 days.

When a targeted controlled substance prescribed in accordance with this subdivision is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.";

and on page 3-4, lines 44-2 by rewriting the lines to read:

"(5) A nurse practitioner shall personally consult with the supervising physician prior to prescribing a targeted controlled substance as defined in Article 5 of this Chapter when all of the following conditions apply:

a. The patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services.

b. The therapeutic use of the targeted controlled substance will, or is expected to exceed a period of 30 days.

When a targeted controlled substance prescribed in accordance with this subdivision is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every

90 days to verify that the prescription remains medically appropriate for the patient.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H 3

HOUSE BILL 243*
Committee Substitute Favorable 3/30/17
Third Edition Engrossed 4/10/17

Short Title: Strengthen Opioid Misuse Prevention (STOP)Act. (Public)

Sponsors:

Referred to:

March 6, 2017

A BILL TO BE ENTITLED

AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE CERTAIN SCHEDULE II OR III CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; REQUIRING HOSPICE AND PALLIATIVE CARE PROVIDERS TO PROVIDE EDUCATION REGARDING PROPER DISPOSAL OF CERTAIN UNUSED CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS; MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; AND REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS.

The General Assembly of North Carolina enacts:

PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"**§ 90-12.7. 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:

a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

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:

1. A family member, friend, or other person.

2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director or a designee may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(3) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the 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.

(c) A pharmacist may dispense an opioid antagonist to a person ~~described in subdivision (b)(1) of this section~~ or organization pursuant to a prescription issued ~~pursuant to~~ 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.

(c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section 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. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.

(d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) 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.

(e) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.

(3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.

(4) The State Health Director acting pursuant to subsection (b) of this section.

(5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-87 reads as rewritten:

"**§ 90-87. Definitions.**

As used in this Article:

...

(26a) "Targeted controlled substance" means any controlled substance included in G.S. 90-90(1) or (2) or G.S. 90-91(d).

...."

SECTION 4. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 6. G.S. 90-106 reads as rewritten:

"**§ 90-106. Prescriptions and labeling.**

(a) ~~Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner.~~ No Schedule II substance shall be dispensed

pursuant to a written or electronic prescription more than six months after the date it was prescribed.

(a1) Electronic Prescription Required; Exceptions. – Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all targeted controlled substances. This subsection does not apply to prescriptions for targeted controlled substances issued by any of the following:

(1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.

(2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility as defined in G.S. 14-32.2.

(3) A practitioner who experiences temporary technological or electrical failure or other extenuating circumstance that prevents the prescription from being transmitted electronically, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(4) A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(a2) Verification by Dispenser Not Required. – A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a targeted controlled substance. A dispenser may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.

(a3) Limitation on Prescriptions Upon Initial Consultation for Acute Pain. – A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance for post-operative acute pain relief immediately following a surgical procedure. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E of the General Statutes, hospice facility, or residential care facility as defined in G.S. 14-32.2(c1).

(a4) Pain Management Agreement Plan for Extended Therapeutic Use of a Targeted Controlled Substance. – If a prescription is for a targeted controlled substance and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 60 days, the practitioner prescribing the targeted controlled substance shall execute a pain management agreement with the patient that includes the following elements:

(1) Agreement date.

(2) Patient name and practitioner name.

(3) Relevant diagnosis/diagnoses.

(4) Name of targeted drug(s), dosage amount, and frequency of administration.

(5) Refill policy.

(6) Other pain management therapies to be used.

(7) Required follow-up with prescribing practitioner.

(8) Random drug testing policy.

(9) Use of Controlled Substances Reporting System by prescribing practitioner.

(10) Acknowledgement by patient that targeted drug(s) cannot be prescribed by other practitioners while the agreement is in force.

(11) Policy for agreement termination.

(a5) Definitions. – As used in this subsection, the following terms have the following meanings:

(1) Acute pain. – Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

(2) Chronic pain. – Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(3) Surgical procedure. – A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

(a6) Dispenser Immunity. – A dispenser shall be immune from any civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of this section.

(b) In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.

(c) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.

(d) No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.

(e) No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.

(f) No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.

(g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.

(h) A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

(i) A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the

requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 7. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.**

Any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall, at the commencement of treatment, provide oral and written information to the patient and his or her family regarding the proper disposal of such targeted controlled substances. This information shall include the availability of permanent drop boxes or periodic "drug take-back" events that allow for the safe disposal of controlled substances such as those permanent drop boxes and events that may be identified through North Carolina Operation Medicine Drop."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

"(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No ~~public~~ State funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

SECTION 9. G.S. 90-113.72 reads as rewritten:

"**§ 90-113.72. Definitions.**

The following definitions apply in this Article:

(1) ~~"Commission" means the~~ Commission. – The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(2) ~~"Controlled substance" means a~~ Controlled substance. – A controlled substance as defined in G.S. 90-87(5).

(3) ~~"Department" means the~~ Department. – The Department of Health and Human Services.

(4) ~~"Dispenser" means a~~ Dispenser. – A person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:

a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

b. Repealed by Session Laws 2013-152, s. 1, effective January 1, 2014, and applicable to prescriptions delivered on or after that date.

c. A wholesale distributor of a Schedule II through V controlled substance.

~~d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.~~

(4a) Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A.

(5) ~~"Ultimate user" means a~~ Ultimate user. – A person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the person's own use, for the use of a member of the person's household,

or for the use of an animal owned or controlled by the person or by a member of the person's household."

SECTION 10. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting ~~system.~~system; civil penalties for failure to properly report.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than ~~the close of business three business days after the day when the prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hours~~the close of the next business day after the prescription is delivered; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system. In the event the dispenser is unable to report the information within the time frame required by this section because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the dispenser's records. Once the electrical or technological failure has been resolved, the dispenser shall promptly report the information.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.

(2) The name of the patient for whom the controlled substance is ~~being~~ dispensed, ~~and the patient's:~~ or if the controlled substance is dispensed for an animal, the name of the owner of the animal and the following information of the patient or owner:

a. Full address, including city, state, and zip code,

b. Telephone number, and

c. Date of birth.

(3) The date the prescription was written.

(4) The date the prescription was filled.

(5) The prescription number.

(6) Whether the prescription is new or a refill.

(7) Metric quantity of the dispensed drug.

(8) Estimated days of supply of dispensed drug, if provided to the dispenser.

(9) National Drug Code of dispensed drug.

(10) Prescriber's DEA number.

(11) Method of payment for the prescription.

(12) If the prescriber is a physician assistant or a nurse practitioner, the name of that individual's supervising physician.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the

ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than one hundred dollars ($100.00) for a first violation, two hundred fifty dollars ($250.00) for a second violation, and five hundred dollars ($500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of five thousand dollars ($5,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74(b1) reads as rewritten:

"(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:

...

(1a) Notify practitioners and their respective licensing boards of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

...."

SECTION 12. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"**§ 90-113.74B. Mandatory dispenser registration for access to controlled substances reporting system; exception.**

(a) Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

(b) This section does not apply to a licensee employed in a pharmacy practice setting where a Schedule II, III, or IV controlled substance will not be dispensed.

"**§ 90-113.74C. Practitioner use of controlled substances reporting system; mandatory reporting of violations.**

(a) Prior to initially prescribing a targeted controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the targeted controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the targeted controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient and the review shall be documented in the patient's medical record.

(b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a targeted controlled substance to the patient in any of the following circumstances:

(1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, or residential care facility as defined in G.S. 14-32.2.

(2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.

(3) The controlled substance is prescribed to a patient in hospice care or palliative care.

(c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

"**§ 90-113.74D. Dispenser use of controlled substances reporting system.**

(a) Prior to dispensing a targeted controlled substance, a dispenser shall review the information in the controlled substances reporting system pertaining to the patient for the preceding 12-month period and document this review under any of the following circumstances:

(1) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user's existing medical condition.

(2) The prescriber is located outside of the usual geographic area served by the dispenser.

(3) The ultimate user resides outside of the usual geographic area served by the dispenser.

(4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser.

(5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following:

a. Over-utilization of the controlled substance.

b. Requests for early refills.

c. Utilization of multiple prescribers.

d. An appearance of being overly sedated or intoxicated upon presenting a prescription.

e. A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks.

(b) If a dispenser has reason to believe a prescription for a targeted controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate.

(c) A dispenser shall be immune from any civil or criminal liability for actions authorized by this section. Failure to review the system in accordance with subsection (a) of this section shall not constitute medical negligence.

"**§ 90-113.75A. Creation of Controlled Substances Reporting System Fund.**

(a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.

(b) The Fund shall consist of the following:

(1) Any moneys appropriated to the Fund by the General Assembly.

(2) Any moneys received from State, federal, private, or other sources for deposit into the Fund.

(c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"**§ 90-113.75B. Annual report to General Assembly and licensing boards.**

Annually on February 1, beginning February 1, 2019, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about targeted controlled substances reported to the system during the preceding calendar year:

(1) The total number of prescriptions dispensed, broken down by Schedule.

(2) Demographics about the ultimate users to whom prescriptions were dispensed.

(3) Statistics regarding the number of pills dispensed per prescription.

(4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.

(5) The number of ultimate users to whom a prescription was dispensed in more than one county.

(6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors, surgeons, palliative care practitioners, oncologists and other practitioners specializing in oncology, pain management practitioners, practitioners who specialize in hematology, including the treatment of sickle cell disease, and practitioners who specialize in treating substance use disorder shall be treated as distinct categories of practitioners.

(7) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

SECTION 13.(a) Section 12F.16(h) of Session Law 2015-241 reads as rewritten:

"**SECTION 12F.16.(h)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DHHS), shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System (CSRS) established under G.S. 90-113.73. DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish ~~the connection to PMP InterConnect.~~interstate connectivity for the CSRS. The Department shall request forty thousand thirty-five dollars ($40,035) to establish ~~the initial interface for PMP InterConnect~~interstate connectivity for the CSRS and thirty thousand dollars ($30,000) for two years of ongoing interstate connectivity service, maintenance, and ~~support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.~~support."

SECTION 13.(b) Section 12F.16(i)(3) of Session Law 2015-241 reads as rewritten:

"(3) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to establish ~~the initial interface for PMP InterConnect,~~ interstate connectivity for the CSRS, as required by subdivision (2) of subsection (f) of this section. ~~This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.~~ Upon receipt of any grant funding used for this purpose or upon identification of other allowable receipts for this purpose, DHHS shall reimburse the General Fund for the costs associated with establishing interstate connectivity for the CSRS. The reimbursement amount shall be limited to the amount of any grant funding received by DHHS for this purpose plus the amount of any allowable receipts used by DHHS for this purpose, but shall not exceed the amount of the nonrecurring funds appropriated in this section."

PART VI. EFFECTIVE DATE

SECTION 14.(a) Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 of this act become effective July 1, 2017.

SECTION 14.(b) Subsections (a), (a1), and (a2) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2020.

SECTION 14.(c) Subsections (a3), (a4), and (a5) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2018.

SECTION 14.(d) G.S. 90-113.75A and G.S. 90-113.75B, as enacted by Section 12 of this act, become effective September 1, 2017.

SECTION 14.(e) Subsection (b) of G.S. 90-113.73(b), as enacted by Section 10 of this act, is effective when it becomes law. The remainder of Section 10 of this act becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the Controlled Substance Reporting System (CSRS) database has the capability to record the information described in Section 10 of this act. The Chief Information Officer shall notify the Revisor of Statutes once the CSRS database has the capability to record the information described in Section 10 of this act.

SECTION 14.(f) The remainder of this act is effective when it becomes law and applies to acts committed 30 days after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 243*

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

H243-ATY-31 [v.1]

Amends Title [NO]
H243-CSTY-16[v.15]

Date 6-14-17 ,2017

Senator Hise

moves to amend the bill on page 3, lines 33-42 by rewriting the lines to read:

"(5) A physician assistant shall personally consult with the supervising physician prior to prescribing a targeted controlled substance as defined in Article 5 of this Chapter when all of the following conditions apply:

a. The patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services.

b. The therapeutic use of the targeted controlled substance will, or is expected to exceed a period of 30 days.

When a targeted controlled substance prescribed in accordance with this subdivision is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.";

and on page 3-4, lines 44-2 by rewriting the lines to read:

"(5) A nurse practitioner shall personally consult with the supervising physician prior to prescribing a targeted controlled substance as defined in Article 5 of this Chapter when all of the following conditions apply:

a. The patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services.

b. The therapeutic use of the targeted controlled substance will, or is expected to exceed a period of 30 days.

When a targeted controlled substance prescribed in accordance with this subdivision is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every

90 days to verify that the prescription remains medically appropriate for the patient.".

SIGNED _____
Amendment Sponsor

SIGNED _____ 6/14/17
Committee Chair if Senate Committee Amendment

ADOPTED 6/14/17 FAILED _____ TABLED _____

HOUSE BILL 403: LME/MCO Claims Reporting/Mental Health Amdts.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 14, 2017
Introduced by:	Reps. Dollar, Lambeth, Dobson, White	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Second Edition H403-CSTR-6		

OVERVIEW: The PCS to House Bill 403 would make various modifications to laws pertaining to local management entities/managed care organizations (LME/MCOs) and to the Medicaid program, as follows:

- ***Part I modifies certain requirements pertaining to LME/MCOs, which manage the provision of publicly-funded behavioral health services throughout the State.***
- ***Part II modifies the Medicaid transformation legislation, enacted in 2015 and amended in 2016, requiring transition of the Medicaid delivery system to capitated contracts with Prepaid Health Plans.***
- ***Part III requires the Department of Health and Human Services (DHHS) to notify the General Assembly every time DHHS submits a Medicaid State Plan amendment for federal approval and every time DHHS decides not to submit a proposed State Plan amendment that was posted to DHHS's website.***
- ***Part IV amends the statutes that govern Medicaid enrollees' appeals and grievances related to actions taken by LME/MCOs to make these statutes conform to changes in the Medicaid federal regulations that recently took effect.***

PART I. LME/MCO MODIFICATIONS

CURRENT LAW/BACKGROUND: S.L. 2011-264 (HB 916), as amended by Section 13, S.L. 2012-151 (SB 191), directed the Department of Health and Human Services (DHHS) to proceed with statewide restructuring of management responsibilities for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders, through the statewide expansion of the Section 1915(b)/(c) Medicaid Waiver and the operation of the waiver by regional LME/MCOs. As directed in the law, statewide expansion was completed by July 2013. LME/MCO operations are governed by Chapter 122C of the General Statutes.

Originally, 11 LME/MCOs were formed, and those have consolidated to the 7 LME/MCOs that currently exist in the State, which include Vaya Health, Partners Behavioral Health, Cardinal Innovations Healthcare Solutions, Sandhills Center, Alliance Behavioral Health, Eastpointe, and Trillium Health Resources.

LME/MCOs originated from area authorities, county programs, and consolidated human services agencies, which later became local management entities (LMEs). Today, all LME/MCOs are structured

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

as area authorities, and county programs and consolidated human services agencies no longer operate. The terms "area authority," "LME," and "LME/MCO" all refer to the same entities.

The LME/MCOs manage funding from 4 primary sources: State-only (single-stream) funding, State and federal Medicaid funds, federal block grant funds, and county funds.

BILL ANALYSIS: **Part I** of the PCS amends several sections of Chapter 122C, The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, and other provisions of law pertaining to LME/MCOs.

Section 1 directs that on the date when Medicaid capitated contracts with Prepaid Health Plans (PHPs) begin: (1) PHPs shall manage all publicly-funded behavioral health services, (2) the LME/MCOs shall be dissolved, and (3) all remaining LME/MCO assets shall be transferred to DHHS and used to satisfy LME/MCO liabilities or to pay for the cost of contracts with PHPs. If the assets transferred to DHHS are insufficient to cover the LME/MCOs' liabilities, the State shall satisfy the liabilities or arrange to transfer the liabilities to the PHPs.

Section 2 of the PCS requires DHHS to specify a standardized electronic format that all LME/MCOs must use to submit data to DHHS regarding claims billed for Medicaid and State-funded services and to work with LME/MCOs to ensure the success of the process for submitting this data. This section lists permissible uses of the data by DHHS and requires DHHS to report on the status of this requirement by February 1, 2018.

Section 3 of the PCS amends the statute pertaining to the powers and duties of the Secretary of DHHS relevant to the mental health, developmental disabilities, and substance abuse services system to require DHHS to use contracts with LME/MCOs for the management of State-only funding, federal block grant funding, and Medicaid funding that include quality outcome measures for covered services. This section is effective January 1, 2018 and applies to contracts entered into on or after the bill becomes law.

Section 4 of the PCS amends various definitions pertaining to the State's mental health, developmental disabilities, and substance abuse services system, including amending the definition of "area director" to clarify that the term refers to the administrative head of the LME/MCO, regardless of the title that individual uses. This section amends other definitions for clarity and to remove obsolete references.

Section 5 of the PCS amends the statute pertaining to the powers and duties of an area authority to codify certain powers and duties that were enacted in uncodified language in S.L. 2011-264.

Section 6 of the PCS amends the statute pertaining to processes that may occur when an area authority is not providing minimally adequate services to specify that those processes may apply when the Secretary of DHHS determines that an area authority or area director has failed to comply with any requirement of State or federal law, rule, or regulation, or any requirement of the area authority's contract with DHHS. The process allows the Secretary to withhold funding from an area authority or assume control of an area authority's management functions after giving the area authority notice and an opportunity to be heard. If the Secretary either withholds funding or assumes control of management functions, the Secretary must develop and oversee a corrective action plan for the area authority. If the area authority does not comply with the corrective action plan, the Secretary, upon notice to the area authority, may appoint a caretaker board and terminate the area director.

Section 7 of the PCS amends the statute pertaining to the area authorities' responsibilities related to their funding to specify that area authorities shall not expend any resources on alcohol, first-class airfare, charter flights, holiday parties or similar social gatherings, or meetings outside the State.

Section 8 of the PCS requires the Office of State Human Resources (OSHR), in collaboration with the Secretary of DHHS and the LME/MCO boards, to take certain actions to revise the job description and salary range for LME/MCO area directors. **Section 8(b)** imposes the following requirements:

- Requires OSHR to update the job description for area directors by September 1, 2017.
- Requires OSHR to recommend a revised salary range to the State Human Resources Commission by December 1, 2017. The recommendation must be based upon a market compensation study of public and not-for-profit organizations nationwide with similar functions to the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographical service areas.
- Requires the State Human Resources Commission to revise the salary range based on this recommendation by March 1, 2018.

Section 8(c) voids the current salary range for area directors and prohibits area authorities from increasing any area director's salary until the new salary range is established, except that vacant area director positions may be filled. **Section 8(d)** requires LME/MCO boards to reestablish the salary for their area director upon the establishment of the new salary range. This requirement would apply to contracts with area directors beginning on or after the date that this act becomes law. **Section 8(e)** authorizes OSHR to recommend to the State Human Resources Commission revisions the salary range for area directors until LME/MCOs are dissolved under **Section 1** of the PCS. Recommendations must be based a market compensation study meeting the same criteria as required for **Section 8(b)**.

Section 9 of the PCS removes obsolete references from Chapter 122C.

EFFECTIVE DATE: Part I of the PCS would be effective when it becomes law.

PART II. MEDICAID TRANSFORMATION MODIFICATIONS

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 (per person per month) contracts with Prepaid Health Plans (PHPs) under an 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS).

BILL ANALYSIS: **Part II** of the PCS makes various changes to the Medicaid transformation legislation, as follows:

- Clarifies rule-making authority pertaining to licensure of PHPs and other aspects of Medicaid transformation.
- Clarifies the definitions of the terms "commercial plan" and "provider-led entity" (PLE).
- Eliminates the exclusion of behavioral health services from PHP coverage for four years after capitated contracts begin.
- Eliminates the exclusion of dental services from PHP coverage.
- Adds an exclusion for the coverage of eyeglasses from PHP coverage.

- Requires Medicare and Medicaid dually-eligible recipients to be covered by PHPs beginning two years after captitated contracts begin, and allows their enrollment to be phased in over a period of up to two years.
- Adds to the list of populations excluded from PHP coverage recipients who are enrolled under the Medicaid Family Planning program and recipients who are inmates of prisons.
- Changes the number of statewide PHP contracts that may be awarded from three to at least three but no more than five.
- Changes the number of regional PLE contracts that may be awarded from 12 to four and allows DHHS to specify any number of regions (current legislation requires six regions).
- Replaces the requirement that PHPs must comply with Chapter 58 of the General Statutes with a requirement to comply with recently-amended federal Medicaid managed care regulations.
- Clarifies that DHHS is authorizes to submit modifications to the 1115 waiver submission to CMS and requires notice to the General Assembly of the submission of any modifications.
- Requires PHPs and hospitals to negotiate mutually acceptable rates.
- Requires that PHP payments to hospitals may not exceed 125% of the fee-for-service rate unless a higher rate is approved by DHHS.
- Requires providers enrolling or reenrolling as a Medicaid provider to agree to accept 90% of the Medicaid fee-for-service rate for the services they provide to PHP enrollees if the provider has been offered a contract with the PHP but is not under a contract with the PHP or has been excluded from a contract with the PHP for failing to meet quality standards.

EFFECTIVE DATE: Part II of the PCS is effective when it becomes law.

PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS

CURRENT LAW: G.S. 108A-54.1A(d) requires DHHS to post amendments to the Medicaid State Plan, including Medicaid waivers and waiver amendments, at least 10 days prior to submitting the amendment to the federal government for approval. The statute requires DHHS to notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division when an amendment is posted to DHHS's website. Current law does not require DHHS to provide notice to the General Assembly when a State Plan amendment has been submitted for federal approval.

BILL ANALYSIS: **Section 12** of the PCS adds requirements for DHHS to give notice to the Joint Legislative Oversight Committee and Medicaid and NC Health Choice and the Fiscal Research Division regarding the submission of State Plan amendments that are posted to DHHS's website in accordance with G.S. 108A-54.1A(d). The PCS requires DHHS to give notice when a State Plan amendment is submitted for federal approval and to give notice when DHHS decides not to submit a proposed State Plan amendment that was posted. The PCS also requires DHHS to give notice upon submission of a modification to a previously-submitted State Plan amendment.

EFFECTIVE DATE: Part III of the PCS is effective when it becomes law and applies to State Plan amendments posted on DHHS's website on or after that date.

PART IV. CONFORMING CHANGES TO LME/MCO APPEALS

CURRENT LAW: Chapter 108D of the General Statutes governs the process for Medicaid beneficiaries who are enrolled with an LME/MCO to appeal decisions made by LME/MCOs and to file grievances with LME/MCOs. Medicaid beneficiaries enroll with an LME/MCO in order to receive behavioral health services. The statutes in Chapter 108D allow enrollees to appeal certain LME/MCO actions through an LME/MCO level (first-level) appeal and to appeal the LME/MCO's resolution of the first-level appeal by requesting a contested case hearing with the Office of Administrative Hearings. The statutes also allow enrollees to file grievances with LME/MCOs related to matters that are not subject to appeal.

The State is required to establish procedures for Medicaid enrollee appeals and grievances in accordance with federal managed care regulations in Part 438 of Title 42 of the Code of Federal Regulations. Effective July 5, 2016, changes were made to these federal regulations that conflict with certain provisions in Chapter 108D.

BILL ANALYSIS: **Section 14** of the PCS amends the definitions pertaining to LME/MCO grievances and appeals by replacing the term "managed care action" with the term "adverse benefit determination" in accordance with a change to that terminology in the federal regulations. Conforming changes are made in **Section 15** of the PCS and throughout the **Part IV** of the PCS.

Section 16 of the PCS amends the statute governing standard LME/MCO level enrollee appeals to do the following:

- Allows enrollees 60 days instead of 30 days to request an LME/MCO level appeal after receiving a notice of adverse benefit determination.
- Requires LME/MCOs to resolve an LME/MCO level appeal and send a notice of resolution to the enrollee within 30 days instead of 45 days after receiving the request for appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 17 of the PCS amends the statute governing expedited LME/MCO level appeals to do the following:

- Requires LME/MCOs to resolve expedited LME/MCO level appeals within 72 hours instead of three working days after receiving the request for expedited appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 18 of the PCS amends the statute governing enrollee contested case hearings to allow enrollees 120 days instead of 30 days after the mailing date of the notice of resolution to file a request for an appeal at the Office of Administrative Hearings.

EFFECTIVE DATE: **Part IV** of the PCS is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

PART V. EFFECTIVE DATE

EFFECTIVE DATE: **Section 3** of the PCS would become effective January 1, 2018. The remainder of the PCS would become effective when the bill becomes law.

HOUSE BILL 403
Committee Substitute Favorable 3/29/17

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

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT MODIFYING CERTAIN REQUIREMENTS PERTAINING TO LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (DHHS) shall specify a single, nationally recognized, standardized electronic format to be used by all local management entities/managed care organizations (LME/MCOs) when submitting encounter data to DHHS. LME/MCOs must submit to 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 utilizing the single, nationally recognized, standardized electronic format specified by DHHS.

SECTION 1.(b) DHHS may use encounter data submitted by LME/MCOs for all of the following purposes:

(1) Setting LME/MCO capitation rates.
(2) Measuring the quality of services managed by LME/MCOs.
(3) Assuring compliance with State and federal regulations.
(4) Conducting oversight and audit functions.
(5) Other purposes determined necessary by DHHS.

SECTION 1.(c) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

SECTION 1.(d) DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services regarding the status of subsection (a) of this section on or before February 1, 2018.

SECTION 2.(a) G.S. 122C-112.1(a)(39) reads as rewritten:

"(39) Develop and use ~~a~~ standard ~~contract~~ contracts for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver and management of State appropriations and federal block grant funds that requires compliance by each LME/MCO with all provisions of the ~~contract~~ contracts to operate the 1915(b)/(c) Medicaid Waiver and manage State appropriations and federal block grant funds and with all applicable provisions of State and federal law. Each of these standard contracts must include quality outcome measures for mental health, developmental disabilities, and substance use disorders."

SECTION 2.(b) This section applies to contracts entered into on or after the effective date of this act.

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

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

(1) "Area authority" means the area mental health, developmental disabilities, and substance abuse authority.

(2) "Area board" means the area mental health, developmental disabilities, and substance abuse ~~board.~~board that is the governing body for the area authority, local management entity, or local management entity/managed care organization.

(2a) "Area director" means the administrative head of the area ~~authority program~~ authority, local management entity, or local management entity/managed care organization appointed pursuant to G.S. 122C-121. All provisions of Chapter 122C of the General Statutes that apply to the area director also apply to the administrative head of the area authority, LME, or LME/MCO, regardless of whether (i) the administrative head uses the title "CEO" or any other name or title assigned to him or her by the area authority, LME, or LME/MCO and (ii) a contract, memorandum of understanding, or other agreement in effect between the Department and the area authority, LME, or LME/MCO refers to the administrative head as the "CEO" or any other name or title.

(2b) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area ~~authorities and multicounty programs.~~authorities.

...

(5) "Catchment area" means the geographic part of the State served by a specific area ~~authority or county program.~~authority.

...

~~(10a) "County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.~~

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority or county program.~~authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area ~~authority or county program.~~authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;
d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;
e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;
f. A "State facility", which is a facility that is operated by the Secretary;
g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and
h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.

...

(20b) "Local management entity" or "LME" means an area ~~authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.~~authority.

...

~~(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.~~

...."

SECTION 4.(a) G.S. 122C-115.4(b) reads as rewritten:

"(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME obtains the prior written approval of the Secretary to voluntarily ~~enters~~ enter into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.
(2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.
(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.
b. Addressing difficult situations for clients or providers.
c. Consulting with providers regarding difficult or unusual care situations.
d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.
e. Coordinating client transitions from one service to another.
f. Conducting customer service interventions.
g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(8) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:

a. Waiting for residential services.
b. Potentially eligible for CAP-MRDD.
c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health,

Developmental Disabilities, and Substance Abuse Services, including CAP-MRDD.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions."

SECTION 4.(b) This section applies to contracts entered into on or after the effective date of this act.

SECTION 5. G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area ~~authority; status of consolidated human services agency.~~authority.**

~~(a)~~ An area authority is a local political subdivision of the ~~State.~~State established by counties pursuant to G.S. 122C-115(a) and (c) for the management and delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance use disorders under a 1915(b)/(c) Medicaid Waiver. An area authority is a local management entity that must perform the local management entity functions described in G.S. 122C-115.4 and monitor and manage all public resources that may be available for mental health, intellectual and developmental disabilities, and substance use disorder services, including federal block grants, federal funding for Medicaid and NC Health Choice, and all other public funding sources as described in Section 1(a) of S.L. 2011-264 and in compliance with G.S. 122C-111 and G.S. 122C-112.1(a)(39). LMEs are the single entities authorized to operate and manage the 1915(b)/(c) Medicaid Waiver, which operation and management must be performed in accordance with a standard contract developed by the Secretary under the authority of G.S. 122C-112.1(a)(39) that is subject to the enforcement provisions of G.S. 122C-124.1, G.S. 122C-124.2, and all other applicable provisions of this Chapter. LMEs are the sole entities authorized to enter into the contract described in G.S. 122C-124.2(g)(2) and G.S. 122C-112.1(a)(39) for the operation of the 1915(b)/(c) Medicaid Waiver. A local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under section 1915(b) and section 1915(c) of the Social Security Act shall be known as a "local management entity/managed care organization" or "LME/MCO."

~~(b) A consolidated human services agency is a department of the county.~~"

SECTION 6.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

…

(7) Appoint an area director in accordance with ~~G.S. 122C-121(d).~~G.S. 122C-121.

…

(18) Maintain disability-specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(19) Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

(20) Maintain full accountability for all aspects of Medicaid Waiver operations and for meeting all contract requirements specified by the Department.

…

(a2) An area authority may, but shall not be required to, subcontract to other entities, upon the prior written approval of the Secretary, only the following managed care functions:

(1) Information systems.

(2) Customer service (including call center) operations.

(3) Claims processing.
(4) Provider, enrollment, credentialing, and monitoring.
(5) Professional services.
(6) Treatment Plan development.
(7) Referral to services.

An area authority shall not subcontract to other entities any other managed care functions or nonservice activities.

...."

SECTION 6.(b) G.S. 122C-117(a2), as enacted by subsection (a) of this section, applies to area authority subcontracts to other entities entered into on or after the date this act becomes law.

SECTION 7.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) An area board shall have no fewer than 11 and no more than 21 voting members. ~~The~~

(a1) Unless the Secretary approves an alternative board appointment process pursuant to subsection (a2) of this section, the board of county commissioners, or the boards of county commissioners within the area, shall appoint members in a manner that ensures participation from each of the constituent counties of the area authority and is consistent with the requirements provided in subsection (b) of this section. ~~The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category.~~ If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint members of the unrepresented categories.

(a2) The boards of county commissioners within a multicounty area with a catchment population of at least 1,250,000 shall have the option to appoint members of the area board ~~in a manner or with a composition~~ through a process other than as required by subsection (a1) of this section ~~by~~ if at least three-quarters of the constituent counties each ~~county adopting~~ adopt a resolution to that effect and ~~receiving~~ obtain written approval from the Secretary. When seeking written approval from the Secretary to use an alternative board appointment process, the area authority shall submit to the Secretary its proposed board appointment process and copies of county resolutions requesting approval of the proposed board appointment process. In cases in which two or more area authorities seek to merge or consolidate, if one or more of these area authorities received approval by the Secretary for an alternative board appointment process prior to the merger or consolidation, all prior approvals for an alternative board appointment process become void 30 days after the effective date of the merger or consolidation. The newly merged or consolidated area authority and the boards of county commissioners within the multicounty area may appoint members of the area board through a process other than as provided in subsection (a1) of this section if at least three-quarters of the constituent counties each adopt a resolution to that effect and obtain written approval from the Secretary in the manner prescribed by this subsection. No area board shall be exempt from, and the Secretary shall not waive, any provision of this section except as provided in subsection (a1) of this section with respect to the board appointment process.

(a3) A member of the board may be removed with or without cause by the ~~initial~~ appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chair of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the ~~initial~~ appointing authority before the end of the term of the vacated seat or within 90 days ~~of~~ after the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) Within the maximum membership provided in subsection (a) of this section, the membership of the area board shall reside within the catchment area and be composed as follows:

(1) At least one member who is a current county commissioner.
(2) The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.
(3) At least one family member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
  a. Individuals with mental illness.
  b. Individuals in recovery from addiction.
  c. Individuals with intellectual or other developmental disabilities.
(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
  a. Individuals with mental illness.
  b. Individuals with intellectual or other developmental disabilities.
  c. Individuals in recovery from addiction.
(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.
(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.
(8) An individual with ~~insurance expertise consistent with the scale and nature of the managed care organization.~~health insurance, health plan administration, or business expertise, or any combination of expertise in these areas.
(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
(10) An attorney with health care expertise.
(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.
(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.
(13) An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

Except as provided in subdivisions (12) and (13) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area ~~authority~~ board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

...

(d1) Beginning on July 1, 2017, each LME/MCO annually shall notify the Secretary of all of the following:

(1) The area board appointment process, the process for filling vacancies on the area board, and the appointing authority for each area board position.

(2) The membership of the area board.

(3) The county of residence of each member.

(4) How the membership composition requirements of subsection (b) of this section are being met.

(5) The term of office of the chair of the area board and each member.

(6) The LME/MCO's compliance status with training requirements for its board members.

(7) The board's policies and procedures for conducting the area director's annual performance review, including at least all of the following:

a. The criteria used to conduct the review.

b. The criteria used to award bonuses to the area director and other employees.

c. The process for soliciting comments from county commissioners.

d. The results of the area director's most recent performance evaluation.

...."

SECTION 7.(b) Any area board that does not meet the composition requirements of G.S. 122C-118.1(b) on the effective date of this act shall comply with these composition requirements no later than October 1, 2017.

SECTION 8.(a) Part 4 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-147.3. LME/MCO use of funds.**

LME/MCOs shall use funds only for purposes related to their functions and responsibilities under this Chapter, including operation of the combined Medicaid Waiver program authorized under section 1915(b) and 1915(c) of the Social Security Act, or to carry out functions and responsibilities required by State law, federal law, or contract with the Department of Health and Human Services. A violation of this section constitutes noncompliance for purposes of G.S. 122C-124.2(c)."

SECTION 8.(b) G.S. 122C-124.2(c) reads as rewritten:

"(c) If the Secretary (i) does not provide a local management entity/managed care organization with the certification of compliance required by this section based upon the LME/MCO's failure to comply with any of the requirements specified in subdivisions (1) through (3) of subsection (b) of this ~~section,~~ section or (ii) determines that an LME/MCO has failed to comply with G.S. 122C-147.3, the Secretary shall do the following:

(1) Prepare a written notice informing the LME/MCO of the provisions of subdivision (1), (2), or (3) of subsection (c) of this section or the provisions of G.S. 122C-147.3 with which the LME/MCO is deemed not to be in compliance and the reasons for the determination of noncompliance.

(2) Cause the notice of the noncompliance to be delivered to the LME/MCO.

(3) Not later than 10 days after the Secretary's notice of noncompliance is provided to the LME/MCO, assign the Contract of the noncompliant LME/MCO to a compliant LME/MCO.

(4) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to the compliant LME/MCO in accordance with the provisions in subsection (e) of this section."

SECTION 9.(a) G.S. 122C-121 reads as rewritten:

"**§ 122C-121. Area director.**

(a) The area director is ~~an~~ a full-time employee of the area board, shall serve full time at the pleasure of the area board, and shall be appointed by the area board in accordance with G.S. 122C-117(7). The area director shall not be employed in any other capacity or enter into any other contract for the performance of services while serving as area director. As used in this subsection, "employee" means an individual and does not include a corporation, a partnership, a limited liability corporation, or any other business association.

(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Human Resources ~~Commission. Any salary that is higher than the maximum of the applicable salary range shall be~~ Commission so long as all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within ~~the~~ a comparable region of North Carolina and shall also include the specific amount the board proposes to pay the director. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary from both the Director of the Office of State Human Resources and the Secretary. In no instance shall the area board, the Director of the Office of State Human Resources, or the Secretary approve a salary for an area director that is higher than the maximum of the applicable salary range if it exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, as determined by the Secretary. If the Secretary determines that an area director's salary is higher than the maximum of the applicable salary range and exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, that area director's salary shall be reduced to achieve compliance with this subdivision within 60 days after such determination by the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(a2) The area board shall not authorize any salary adjustment for an area director that ~~is~~ results in a salary above the normal allowable salary ~~range without obtaining prior approval from the Director of the Office of State Human Resources.~~range, or pay any salary above the normal allowable salary range, unless all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within a comparable region of North Carolina and shall also include the specific amount of the salary adjustment the board proposes to pay the area director and the resulting salary. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary adjustment from both the Director of the Office of State Human Resources and the Secretary. In no instance shall the area board, the Director of the Office of State Human Resources, or the Secretary approve a salary adjustment for an area director that results in a salary that is higher than the maximum of the applicable salary range if it exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, as determined by the Secretary. If the Secretary determines that an area director's salary is higher than the maximum of the applicable salary range and exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, that area director's salary shall be reduced to achieve compliance with this subdivision within 60 days after such determination by the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(a3) If the Secretary determines that the compensation of an area director, including salary, benefits, and bonuses, exceeds the limitations specified in this section, the area board shall prospectively reduce that area director's compensation, including salary, benefits, and bonuses, to achieve compliance with this section and notify the Secretary within 60 days after such determination by the Secretary. If an area board does not bring an area director's compensation, including salary, benefits, and bonuses, into compliance with this section within the 60-day period, the Secretary shall notify, in writing, the area board and the applicable participating boards of county commissioners of the area authority specifically how the Secretary determined that the area director's compensation, including salary, benefits, and bonuses, does not comply with this section, and that the area board must bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section or a caretaker board of directors will be appointed as provided in G.S. 122C-124.1(c). The area board shall have 60 days from the date it receives notice under this subsection to bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section.

If, at the end of the 60-day notice period, the area board has not brought the area director's compensation, including salary, benefits, and bonuses, into compliance with this section, the Secretary shall appoint a caretaker board of directors as provided in G.S. 122C-124.1(c). The Secretary may assign any or all of the powers and duties of the area director or of the area board to the caretaker board as the Secretary deems necessary and appropriate. In addition to performing all of these powers and duties, the caretaker board shall bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section. The Secretary may terminate the area director's employment when it appoints a caretaker board. Neither party to any applicable employment contract shall be entitled to damages. After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area authority.

~~(a2)~~(a4) The area board shall not provide the area director with any benefits or bonuses that are not also provided by the area board to all permanent employees of the area program, except that the area board may, in its discretion, offer severance benefits, relocation expenses, or both, to an applicant for the position of area director as an incentive for the applicant to accept an offer of employment. The area director shall be reimbursed only for allowable

employment-related expenses at the same rate and in the same manner as other employees of the area program.

(a5) The total compensation provided or recommended to be provided by each area board to its area director, including salary, benefits, and bonuses, shall be reviewed for written approval by the Director of the Office of State Human Resources and the Secretary on at least an annual basis to determine compliance with the requirements of this section. An area board shall not increase compensation to an area director without prior written approval for the increase from the Director of the Office of State Human Resources and the Secretary.

(a6) Annually on June 30, each area board shall submit to the Secretary and the Director of the Office of State Human Resources a copy of all current employment agreements, employment contracts, and any amendments to those agreements and contracts that the area board has entered into with its area director, as well as any other documents relating to the area director's compensation, including salary, benefits, and bonuses.

(b) The Secretary and the area board shall evaluate annually the area director for performance based on criteria established by the Secretary and the area board. In conducting the evaluation, the Secretary and the area board shall consider comments from the board of county commissioners.

(c) The area director is the administrative head of the area program. In addition to the duties under G.S. 122C-111, the area director shall:

(1) Appoint, supervise, and terminate area program staff.
(2) Administer area authority services.
(3) Develop the budget of the area authority for review by the area board.
(4) Provide information and advice to the board of county commissioners through the county manager.
(5) Act as liaison between the area authority and the Department.
(6) Ensure compliance by the area authority with the powers and duties of the area authority established under G.S. 122C-117.

(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:

(1) Masters degree.
(2) Related experience.
(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1.

(e) The appointment of the area director shall be based upon the recommendation of at least two candidates by a search committee of the area board. The search committee shall include a consumer board member, a county commissioner, and an appointee of the Secretary. The Secretary may waive this requirement when appointment of the area director results from the merger or consolidation of LME/MCOs.

(f) The area board may not terminate the employment of an area director without 30 days' prior written notice to the Secretary, unless the termination (i) results from the merger or consolidation of LME/MCOs or (ii) is directed by the Secretary."

SECTION 9.(b) The limitations on compensation, including salary, benefits, and bonuses specified in G.S. 122C-121, as amended by subsection (a) of this section, apply to currently employed area directors hired prior to the effective date of this act as well as to area directors hired on or after the effective date of this act. If the Secretary of the Department of Health and Human Services determines that the compensation, including salary, benefits, and bonuses, of a currently employed area director hired prior to the effective date of this act exceeds the limitations specified in G.S. 122C-121, as amended by subsection (a) of this section, the area board shall prospectively reduce that area director's compensation, including salary, benefits, and bonuses, to achieve compliance with G.S. 122C-121, as amended by subsection (a) of this section, within 60 days after such determination by the Secretary. If an

area board does not comply with the directive of this subsection to reduce an area director's compensation, including salary, benefits, and bonuses, to achieve compliance with G.S. 122C-121, as amended by subsection (a) of this section, within the 60-day period prescribed by this subsection, the Secretary shall appoint a caretaker board of directors, as prescribed in G.S. 122C-121(a3), as amended by subsection (a) of this section.

SECTION 9.(c) Each LME/MCO shall, within 30 day after the effective date of this act, submit to the Secretary and the Director of the Office of State Human Resources a copy of all current employment agreements, employment contracts, and any amendments to those agreements and contracts that the LME/MCO has entered into with its area director, as well as any other documents relating to the area director's compensation, including salary, benefits, and bonuses.

SECTION 10. G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

(a) Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. ~~Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1.~~

(b) Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Human Resources ~~Commission. Any salary that is higher than the maximum of the applicable salary range shall~~ Commission so long as all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within ~~the~~ a comparable region of North Carolina and shall also include the specific amount the board proposes to pay the employee. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary from both the Director of the Office of State Human Resources and the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(c) The area board shall not authorize any salary adjustment that ~~is~~ results in a salary above the normal allowable salary range ~~without obtaining prior approval the Director of the Office of State Human Resources.~~ unless all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within a comparable region of North Carolina and shall also include the specific amount of the salary adjustment the board proposes to pay the employee and the resulting salary. For the purpose of this subdivision, the Secretary shall determine what

constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary adjustment from both the Director of the Office of State Human Resources and the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes."

SECTION 11. G.S. 126-11 reads as rewritten:

"**§ 126-11. Local personnel system may be established; approval and monitoring; rules and regulations.**

(a) The board of county commissioners of any county may establish and maintain a personnel system for all employees of the county subject to its jurisdiction, which system and any substantial changes to the system, shall be approved by the State Human Resources Commission as substantially equivalent to the standards established under this Chapter for employees of local departments of social services, local health departments, ~~and~~ area mental health programs, and local emergency management programs. If approved by the State Human Resources Commission, the employees covered by the county system shall be exempt from all provisions of this Chapter except Article 6.

(a1) With approval of each of the boards of commissioners of the county or counties which comprise the area mental health authority, the area mental health authority may establish and maintain a personnel system for all employees of the area mental health authority, which system and any substantial changes to the system, shall be equivalent to the standards established under this Chapter for employees of area mental health authorities. If approved by the State Human Resources Commission, the employees covered by the area mental health authority system shall be exempt from all provisions of this Chapter except Article 6.

(b) A board of county commissioners may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements ~~in (a) above.~~ of subsection (a) of this section. Upon such determination, county employees shall be exempt from the provisions of this Chapter relating to the approved portions of the county personnel system.

(b1) The board of an area mental health authority, with the approval of each of the boards of commissioners of the county or counties which comprise the area mental health authority, may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements ~~in subsection (a1) above.~~ of subsection (a1) of this section. Upon such determination, area mental health authority employees shall be exempt from the provisions of this Chapter relating to the approved portions of the area mental health authority personnel system except as provided in G.S. 122C-121.

(b2) Upon the merger or consolidation of two or more local management entities/managed care organizations, any determination made prior to the effective date of that merger or consolidation that all or a portion of any applicable area mental health authority personnel system is substantially equivalent is void. The board of the newly merged or consolidated area mental health authority, with the approval of the boards of commissioners of three-quarters of the counties which comprise the newly merged or consolidated area mental health authority, may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements of subsection (a1) of this section. Upon such determination, area mental health authority employees shall be exempt from

the provisions of this Chapter relating to the approved portions of the area mental health authority personnel system except as provided in G.S. 122C-121 and G.S. 122C-154.

(c) The Office of State Human Resources shall monitor at least annually county or area mental health authority personnel systems approved under this section in order to ensure compliance.

(d) In order to define "substantially equivalent," the State Human Resources Commission is authorized to promulgate rules and regulations to implement the federal merit system standards and these regulations at a minimum shall include: recruitment and selection of employees; position classification; pay administration; training; employee relations; equal employment opportunity; and records and reports."

SECTION 12. Section 12F.2(a) of S.L. 2015-241 reads as rewritten:

"**SECTION 12F.2.(a)** For the purpose of mitigating cash flow problems that many LME/MCOs experience at the beginning of each fiscal year relative to single stream funding, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), shall distribute not less than one-twelfth of each LME/MCO's ~~continuation~~ base budget allocation at the beginning of the fiscal year and subtract the amount of that distribution from the LME/MCO's total reimbursements for the fiscal year. For each month of the fiscal year after July, the DMH/DD/SAS shall distribute, on the first Tuesday of the month, one-eleventh of the amount of each LME/MCO's single-stream allocation that remains after subtracting the amount of the distribution that was made to the LME/MCO in July of the fiscal year."

SECTION 13. G.S. 122C-141(d)(1) reads as rewritten:

"(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Commission. ~~A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.~~"

SECTION 14. G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the General Statutes are repealed.

SECTION 15. The Revisor of Statutes shall delete every reference to G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human services agency" wherever they occur in Chapter 122C of the General Statutes.

SECTION 16. Section 12 of this act becomes effective July 1, 2017. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 403
Committee Substitute Favorable 3/29/17
PROPOSED SENATE COMMITTEE SUBSTITUTE H403-CSTR-6 [v.12]
06/13/2017 5:58:12 PM

Short Title: Behavioral Health and Medicaid Modifications. (Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO MODIFY CERTAIN REQUIREMENTS PERTAINING TO LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS, TO MODIFY THE MEDICAID TRANSFORMATION LEGISLATION, TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO NOTIFY THE GENERAL ASSEMBLY UPON THE SUBMISSION OR NON-SUBMISSION OF A MEDICAID STATE PLAN AMENDMENT, AND TO MAKE CHANGES TO THE NORTH CAROLINA LME/MCO ENROLLEE GRIEVANCES AND APPEALS STATUTES TO CONFORM WITH RECENT CHANGES TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

PART I. LME/MCO MODIFICATIONS

SECTION 1. On the date when Medicaid capitated contracts with Prepaid Health Plans (PHPs) begin, as required by S.L. 2015-245, all of the following shall occur:

(1) PHPs shall manage all publicly-funded behavioral health services currently managed by the local management entities/managed care organizations (LME/MCOs) under contracts with the Department of Health and Human Services (DHHS).

(2) The LME/MCOs shall be dissolved.

(3) All remaining assets of the LME/MCOs, including all funds in the Medicaid risk reserve account shall be transferred to DHHS to be used to satisfy the liabilities of the LME/MCOs and for costs of the contracts with PHPs for the management of publicly-funded behavioral health services. In the event there are insufficient assets to satisfy the liabilities of the LME/MCOs, it shall be the responsibility of the Secretary to satisfy the liabilities of the LME/MCOs or arrange for the transfer of those liabilities to PHPs.

SECTION 2.(a) The Department of Health and Human Services (DHHS) shall specify a single, nationally recognized, standardized electronic format to be used by all local management entities/managed care organizations (LME/MCOs) when submitting encounter data to DHHS. LME/MCOs must submit to 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 utilizing the single, nationally recognized, standardized electronic format specified by DHHS.

SECTION 2.(b) DHHS may use encounter data submitted by LME/MCOs for all of the following purposes:

(1) Setting LME/MCO capitation rates.
(2) Measuring the quality of services managed by LME/MCOs.
(3) Assuring compliance with State and federal regulations.
(4) Conducting oversight and audit functions.
(5) Other purposes determined necessary by DHHS.

SECTION 2.(c) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

SECTION 2.(d) DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services regarding the status of subsection (a) of this section on or before February 1, 2018.

SECTION 3.(a) G.S. 122C-112.1(a)(39) reads as rewritten:

"(39) Develop and use ~~a~~ standard ~~contract~~ contracts for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver and management of State appropriations and federal block grant funds that requires compliance by each LME/MCO with all provisions of the ~~contract~~ contracts to operate the 1915(b)/(c) Medicaid Waiver and manage State appropriations and federal block grant funds and with all applicable provisions of State and federal law. Each of these standard contracts must include quality outcome measures for mental health, developmental disabilities, and substance use disorders."

SECTION 3.(b) This section is effective January 1, 2018 and applies to contracts entered into on or after that date.

SECTION 4. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

(1) "Area authority" means the area mental health, developmental disabilities, and substance abuse authority.

(2) "Area board" means the area mental health, developmental disabilities, and substance abuse ~~board.~~board that is the governing body for the area authority, local management entity, or local management entity/managed care organization.

(2a) "Area director" means the administrative head of the area ~~authority program~~ authority, local management entity, or local management entity/managed care organization appointed pursuant to G.S. 122C-121. All provisions of Chapter 122C of the General Statutes that apply to the area director also apply to the administrative head of the area authority, LME, or LME/MCO, regardless of whether (i) the administrative head uses the title "CEO" or any other name or title assigned to him or her by the area authority, LME, or LME/MCO and (ii) a contract, memorandum of understanding, or other agreement in effect between the Department and the area authority, LME, or LME/MCO refers to the administrative head as the "CEO" or any other name or title.

(2b) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area ~~authorities and multicounty programs.~~authorities.

...

(5) "Catchment area" means the geographic part of the State served by a specific area ~~authority or county program.~~ authority.

...

~~(10a) "County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.~~

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority or county program.~~authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area ~~authority or county program.~~authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

...

...

(20b) "Local management entity" or "LME" means an area ~~authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.~~authority.

...

~~(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.~~

...."

SECTION 5. G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with ~~G.S. 122C-121(d).~~G.S. 122C-121.

...

(18) Maintain disability-specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(19) Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

(20) Maintain full accountability for all aspects of Medicaid Waiver operations and for meeting all contract requirements specified by the Department."

SECTION 6. G.S. 122C-124.1 reads as rewritten:

"**§ 122C-124.1. Actions by the Secretary upon area authority or area director failure to comply or when area authority ~~or county program~~ is not providing minimally adequate services.**

(a) Notice of Likelihood of Action. – When the Secretary determines that there is a likelihood of suspension of funding, assumption of service delivery or management functions, or appointment of a caretaker board under this section within the ensuing 60 days, the Secretary shall so notify in writing the area authority board ~~or the county program~~ and the board of county commissioners of the area ~~authority or county program.~~authority. The notice shall state the particular deficiencies in program services or administration that must be remedied to avoid

action by the Secretary under this section. The area authority board ~~or county program~~ shall have 60 days from the date it receives notice under this subsection to take remedial action to correct the deficiencies. The Secretary shall provide technical assistance to the area authority ~~or county program~~ in remedying deficiencies.

(b) Suspension of Funding; Assumption of Service Delivery or Management Functions. – If the Secretary determines that ~~a county, through~~ (i) an area authority or ~~county program,~~ area director has failed to comply with any requirement of State or federal law, rule, or regulation, or any requirement of the area authority's contract with the Department; or (ii) an area authority is not providing minimally adequate services to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, then the Secretary, after providing written notification of the Secretary's intent to the area authority ~~or county program~~ and to the board of county commissioners of the area ~~authority or county program,~~ authority, and after providing the area authority ~~or county program~~ and the boards of county commissioners of the area authority ~~or county program~~ an opportunity to be heard, may:

(1) Withhold funding for the particular service or services in question from the area authority ~~or county program~~ and ensure the provision of these services through contracts with public or private agencies or by direct operation by the Department.

Upon suspension of funding, the Department shall direct the development and oversee implementation of a corrective plan of action and provide notification to the area authority ~~or county program~~ and the board of county commissioners of the area authority ~~or county program~~ of any ongoing concerns or problems with the area authority's ~~or county program's~~ finances or delivery of services.

(2) Assume control of the particular service or management functions in question or of the area authority ~~or county program~~ and appoint an administrator to exercise the powers assumed. This assumption of control shall have the effect of divesting the area authority ~~or county program~~ of its powers in G.S. 122C-115.1 and G.S. 122C-117 and all other service delivery powers conferred on the area authority ~~or county program~~ by law as they pertain to this service or management function. County funding of the area authority ~~or county program~~ shall continue when the State has assumed control of the catchment area or of the area ~~authority or county program.~~authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area ~~authority or county program.~~authority.

Upon assumption of control of service delivery or management functions, the Department shall, in conjunction with the area ~~authority or county program,~~ authority, develop and implement a corrective plan of action and provide notification to the area authority ~~or county program~~ and the board of county commissioners of the area authority ~~or county program~~ of the plan. The Department shall also keep the area authority board and the board of county commissioners informed of any ongoing concerns or problems with the delivery of services.

(c) Appointment of Caretaker Administrator. – In the event that a county, through an area ~~authority or county program,~~ authority, fails to comply with the corrective plan of action required when funding is suspended or when the State assumes control of service delivery or management functions, the Secretary, after providing written notification of the Secretary's intent to the area authority ~~or county program~~ and the applicable participating boards of county commissioners of the area ~~authority or county program,~~ authority, shall appoint a caretaker administrator, a caretaker board of directors, or both.

The Secretary may assign any of the powers and duties of the area director or program director or of the area authority board or board of county commissioners of the area authority ~~or county program~~ pertaining to the operation of mental health, developmental disabilities, and substance abuse services to the caretaker board or to the caretaker administrator as it deems necessary and appropriate to continue to provide direct services to clients, including the powers as to the adoption of budgets, expenditures of money, and all other financial powers conferred on the area authority ~~or county program~~ by law pertaining to the operation of mental health, developmental disabilities, and substance abuse services. County funding of the area authority ~~or county program~~ shall continue when the State has assumed control of the financial affairs of the program. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area ~~authority or county program.~~ authority. The caretaker administrator and the caretaker board shall perform all of these powers and duties. The Secretary may terminate the area director ~~or program director~~ when it appoints a caretaker administrator. Chapter 150B of the General Statutes shall apply to the decision to terminate the area ~~director or program~~ director. Neither party to any such contract shall be entitled to damages. After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area ~~authority or county program.~~authority."

SECTION 7. G.S. 122C-151 reads as rewritten:

"**§ 122C-151. Responsibilities of those receiving appropriations.**

(a) All resources allocated to and received by any area authority and used for programs of mental health, developmental disabilities, substance abuse or other related services are subject to the conditions specified in this Article and to the rules of the Commission and the Secretary and to the conditions of the ~~Memorandum of Agreement specified in G.S. 122C-143.2.~~ memorandum of agreement with the Secretary specified in G.S. 122C-115.2(d). Area authorities shall not use any resources for any of the following expenses:

(1) Alcohol.
(2) First-class airfare.
(3) Charter flights.
(4) Holiday parties or similar social gatherings.
(5) Any meeting, whether a formal public meeting or an informal retreat, of the area board outside of the State.

(b) If an area authority fails to complete actions necessary for ~~the development of a Memorandum of Agreement~~ the memorandum of agreement, fails to file required reports within the time limit set by the Secretary, or fails to comply with any other requirements specified in this Article, the Secretary may:

(1) Delay payments; and
(2) With written notification of cause and subject to an appeal as provided by G.S. 122C-151.2, reduce or deny payment of funds. Restoration of funds upon compliance is within the discretion of the Secretary."

SECTION 8.(a) The definitions in G.S. 122C-3 apply to this section.

SECTION 8.(b) The Office of State Human Resources and the State Human Resources Commission shall revise and update the job description and salary range for area directors as follows:

(1) No later than September 1, 2017, the Office of State Human Resources, in collaboration with the Secretary of the Department of Health and Human Services and the LME/MCO area boards, shall revise and update the job description for area directors, taking into account the LME/MCOs' functions and current size, including number of covered lives, annual service and administrative expenditures, and geographic service areas.

(2) No later than December 1, 2017, the Office of State Human Resources shall recommend to the State Human Resources Commission a revision to the salary range for area directors. In forming its recommendation, the Office of State Human Resources shall conduct a market compensation study of organizations nationwide with similar functions as the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographic service areas. The market compensation study shall include both public and not-for-profit managed care organizations. In forming its recommendation, the Office of State Human Resources shall seek input from the Secretary of the Department of Health and Human Services and the LME/MCO area boards.

(3) No later than March 1, 2018, the State Human Resources Commission shall revise the salary range for area directors based on the recommendation of the Office of State Human Resources. Once a new salary range for area directors is adopted, the State Human Resources Commission shall inform each LME/MCO's area board of the new salary range.

SECTION 8.(c) The salary range for area directors, which was last updated by the State Human Resources Commission in 2010, is void. Beginning on the date this act becomes law, the LME/MCO area boards shall not authorize any increase in the salaries of an area director until the Office of State Human Resources and the State Human Resources Commission complete a revision and update of the job description and salary range of the area directors as required by subsection (b) of this section. This section shall not be construed to prohibit an LME/MCO from authorizing a salary pursuant to G.S. 122C-121(a1) to be paid to an area director filling a vacant position after the date this act becomes law.

SECTION 8.(d) After completion of the revision and update required by subsection (b) of this section, each LME/MCO area board shall reestablish the salary for its area director in accordance with G.S. 122C-121(a1). This subsection applies to contracts with area directors beginning on or after the date that the State Human Resources Commission revises the salary range for area directors as required by subdivision (3) of subsection (b) of this section.

SECTION 8.(e) After the date that the State Human Resources Commission revises the salary range for area directors as required by subdivision (3) of subsection (b) of this section and until the LME/MCOs are dissolved pursuant to Section 1 of this act, the Office of State Human Resources, at the discretion of the Director of the Office of State Human Resources, may recommend to the State Human Resources Commission adjustments to the salary range for area directors. In forming a recommendation under this subsection, the Office of State Human Resources shall conduct a market compensation study of organizations nationwide with similar functions as the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographic service areas. The market compensation study shall include both public and not-for-profit managed care organizations. In forming a recommendation under this subsection, the Office of State Human Resources shall seek input from the Secretary of the Department of Health and Human Services and the LME/MCO area boards.

SECTION 9.(a) G.S. 122C-141(d)(1) reads as rewritten:

"(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Commission. ~~A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.~~"

SECTION 9(b). G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the General Statutes are repealed.

SECTION 9(c). The Revisor of Statutes shall delete every reference to G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human services agency" wherever they occur in Chapter 122C of the General Statutes.

PART II. MEDICAID TRANSFORMATION MODIFICATIONS

SECTION 10. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, 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 shall be responsible for planning and implementing the Medicaid transformation required by this act. DHHS shall have the authority to adopt rules related to the activities listed in this section and the regulation of PHPs, except that any rules adopted relating to PHP licensure under Chapter 58 of the General Statutes and Section 6 of this act shall be adopted by the Department of Insurance.

(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that holds a PHP license issued by the Department of Insurance and that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this section. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:

a. Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and ~~holds a PHP license issued by the Department of Insurance.~~ is not a PLE.

b. Provider-led entity or PLE. – An entity that meets all of the following criteria:

1. A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section or Medicaid and NC Health Choice providers.

2. A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have sufficient experience treating beneficiaries of the North Carolina Medicaid ~~program.~~ program, as determined by the Secretary of DHHS.

~~3. Holds a PHP license issued by the Department of Insurance.~~

...

(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) for four years after the date capitated contracts begin.~~

~~b. Dental services~~.

...

g. The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames."

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

a. Recipients who are dually eligible for Medicaid and ~~Medicare.~~ Medicare for two years after the date capitated contracts begin. 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.~~ As recommended by DHHS in its "Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries" dated January 31, 2017, enrollment of dually eligible recipients shall begin two years after the date capitated contracts begin, may be phased as described in DHHS's January 31, 2017 report, and shall be completed within two years after the date that dually eligible recipients are first enrolled with PHPs.

...

h. Recipients enrolled under the Medicaid Family Planning program.

i. Recipients who are inmates of prisons.

(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~~ No less than three and no more than five 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 ~~12~~ 4 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.

...

(6a) ~~To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act,~~ PHPs shall comply with the requirements of ~~Chapter 58 of the General Statutes.~~ of Part 438 of Title 42 of the Code of Federal Regulations.~~This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations.~~ The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.

b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.

c. Proposed statutory changes necessary to implement this subdivision.

...

~~(9) LME/MCOs. LME/MCOs shall continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin. During this four-year period, the Division of Health Benefits shall continue to negotiate actuarially sound capitation rates directly with the LME/MCOs in the same manner as currently utilized. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits during the four-year period.~~"

SECTION 11. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan ~~amendments~~ amendments, as well as any modifications to these submissions, necessary to accomplish the requirements of this act within the required time frames. If DHHS submits any modification to these submissions, DHHS shall provide notice in accordance with G.S. 108A-54.1A(d1).

(2) Define ~~six~~ regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in Section 1 of this act. Every county in the State must be assigned to a region.

...

(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 shall develop standardized contract terms, to include at a minimum, the following:

...

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. PHPs and hospitals must negotiate mutually acceptable rates, methods, and terms of payment.

d1. A requirement that the negotiated payments to hospitals may not exceed one hundred twenty-five percent (125%) of the fee-for-service Medicaid rate unless specifically approved by DHHS.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(7a) Require providers enrolling or reenrolling as a Medicaid or NC Health Choice provider to agree to accept ninety percent (90%) of the Medicaid fee-for-service rate for the services they provide to PHP enrollees if the provider has been offered a contract with a PHP but the provider is not under a contract with that PHP, or if the provider is excluded from contracting with the PHP for failure to meet objective quality standards. DHHS shall implement this requirement within 30 days after this subdivision becomes law, unless a waiver by the Centers for Medicare and Medicaid Services is required as provided in 42 C.F.R. 431.55(f). If a waiver is required, DHHS shall implement this requirement upon CMS's approval of that waiver.

...."

PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS

SECTION 12. G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) The Department of Health and Human Services 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, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

(b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(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 Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval.

(d1) Upon the submission of an amendment to the State Plan or a modification to a previously submitted amendment to the State Plan to the federal government, the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the amendment or modification has been submitted.

If the Department determines that an amendment posted on its Web site in accordance with subsection (d) of this section will not be submitted to the federal government, then the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division upon making that determination.

(e) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(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 Medicaid and NC Health Choice and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 13. This Part is effective when it becomes law and applies to amendments to the State Plan posted on the Department of Health and Human Services Web site on or after that date.

PART IV. CONFORMING CHANGES TO LME/MCO APPEALS

SECTION 14. G.S. 108D-1 reads as rewritten:

"**§ 108D-1. Definitions.**

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

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).

~~(1)~~(1a) Applicant. – A provider of mental health, intellectual or developmental disabilities, and substance abuse services who is seeking to participate in the closed network of one or more local management entity/managed care organizations.

(2) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about ~~a managed care action.~~an adverse benefit determination.

(4) Department. – The North Carolina Department of Health and Human Services.

(5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(6) Emergency services. – As defined in 42 C.F.R. § 438.114.

(7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local management entity/managed care organization.

(8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).

(9) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3(20c).

~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~

(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.

(12) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department of Health and Human Services and a local management entity to operate a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed

network of one or more local management entity/managed care organizations.

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

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

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

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

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

SECTION 15. G.S. 108D-12(a) reads as rewritten:

"(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than ~~a managed care action.~~an adverse benefit determination. Upon receipt of a grievance, an LME/MCO shall cause a written acknowledgment of receipt of the grievance to be sent by United States mail."

SECTION 16. G.S. 108D-13 reads as rewritten:

"**§ 108D-13. Standard LME/MCO level appeals.**

(a) Notice of ~~Managed Care Action.~~Adverse Benefit Determination. – An LME/MCO shall provide an enrollee with a written notice of ~~a managed care action~~ adverse benefit determination by United States mail as required under 42 C.F.R. § 438.404. The notice of action will employ a standardized form included as a provision in the contracts between the LME/MCOs and the Department of Health and Human Services.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~adverse benefit determination. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal in writing by United States mail.

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

(d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f)."

SECTION 17. G.S. 108D-14 reads as rewritten:

"**§ 108D-14. Expedited LME/MCO level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for an expedited appeal of ~~a managed care~~

~~action~~ an adverse benefit determination no later than 30 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

...

(d) Notice of Resolution. – If the LME/MCO grants a request for an expedited LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this ~~three-day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~section or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

...."

SECTION 18. G.S. 108D-15 reads as rewritten:

"**§ 108D-15. Contested case hearings on disputed managed care actions.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

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

...

(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

...

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

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

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

(3) A preprinted statement that indicates that the enrollee would like to appeal a specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

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

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

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

...

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

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

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

(3) Failed to use proper procedure.

(4) Acted arbitrarily or capriciously.

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

...."

SECTION 19. This Part is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

PART V. EFFECTIVE DATE

SECTION 20. Except as otherwise provided, this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, June 14, 2017

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

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

HB **248** **(CS#1)** Support for Older Adults & DHHS Study.

Draft Number:	H248-PCS40600-SH-25
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Ralph Hise will handle HB 248

SPEAKER SIGN-UP SHEET

Senate Committee On Health

June 14, 2017 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
DR. STEVEN STELMA	NCVMA (HB243)

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 14, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
ALAN DELAPENA	DHHS - DPH
Carla Obiol	Care 4 Carolina - AHA
[illegible]	[illegible]
[illegible]	DHHS
Alex Miller	AMGA
[illegible]	NC Board of Nursing
BOBBY D WHITE	NC DENTAL BOARD
[illegible]	NCSEC
Mark Ezzell	APNC
Andy Chase	KMA
[illegible]	CSA
[illegible]	Bona : ASO
[illegible]	DHHS
[illegible]	Benchmark
[illegible]	Vista Strategies
Adam Stolan	NCHCFA
Ashley [illegible]	NC [illegible]

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 14, 2017

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Suzanne Merrill	DHHS/DAAS
Victor Orija	DHHS/DAAS
AMES SIMMONS	EQUALITY NC
Ben Popkin	DHHS
John Nash	The Arc of NC
Rachel Bagley	PB law
Ashley Peterson	Peterson Law
Katie Gammon	Gov
Justin Clayton	Governor
LT McCrimmon	DHHS
Caitlin Little	UNC SOG
Rhaeoan Jackson	Focus Carolina
Kathy Kruger	OP
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Senate Committee on Health Care

June 14, 2017

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Bradford Sneeden	NC DOJ
Paul Fogleman	HTGAC
Amanda Flynn	JDA
Sara Wilson	Alliance BHC
Meri Igwe	Mutual Drug (Student)
	CSS
ALBERT R. BELL Jr	WBS
RICK BUNIO MD	NCMS
Geri Mattson, MD	NCMS
Sue Ann Forrest	NCMS
Daniel McKearney	NCMS
George Stamatakos	NCMS
Ravin Mehta	NCMS

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Senate Committee on Health Care

June 14, 2017

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Jon Lee	Jordan Price Law Office
Jennifer Jones Shults, DVM	NCVMA
Claire Fogleman	NCVMA
Dr. Steven Stelma	NCVMA
Chris McClure	BP
Angel Lopez-Collazo	Governor's Office
Kushal Kadakia	Governor's Office
Caroline Tervo	Governor's Office
Carson Thie	MVA
Ray Rippelmeyer	ACS CAN
Bob Hedrick	NCPL
Kari Barshess	Kaiser Gateway Health
Susanna Dinis	OSHR
LC Perryman	CSS
TJ Bugbee	NP
Courtney Johnson	NP

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Senate Committee on Health Care

June 14, 2017

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Christine Craig	WakeMed
Will Morgan	MFS
Rick Zechini	Williams Mullen
	MFS
Mclean Pirel	NCGA
Dodie Renfer	CCR
Lori Kroll	Novant
Ryan Blankenship	Conn Health
Cindy Hard	NCHA
Dana Simpson	SA
Amanda Donovan	KTS
Joe Winn	Aetna
Daniel Baum	Troutman Sanders
Peyton Maynard	

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Senate Committee on Health Care

June 14, 2017

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Doug Miskew	PSG
Julia Adams Scheurich	Oak City GR
TRACY COLVARD	AT&T
Tony Mawson	City of Wilm
[illegible]	BCI
Mary Harper	NCCP
Ann Rodriguez	NC Council of Comm Programs
Michelle Frazier	SML
Ed [illegible]	BP
JERRY COHEN	RM
John DeBOINO	Brabafort Assoc
Sarah Bales	" "
Deb Clary	NCSP
[illegible]	NCAFP
D. Landon Allen	NCAFP

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 14, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Kimbrell	Parker Poe
[illegible]	NCHCS
Mardy Peal	WellCare
Kelly Vogel	KV Strategies
Mike McTiernan	Biogen
[illegible]	[illegible]
Sarah Wolfe	MWC
[illegible]	MWC
[illegible]	TAG

Senate Committee on Health Care
Thursday, June 15, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 15, 2017, in Room 643 of the Legislative Office Building. Seventeen members were present.

Sen. Ralph Hise, Chair, presided.

Sen. Hise opened the meeting by recognizing the pages–Kristina Edwards of Raleigh, Lillian Nguyen of Charlotte, Melanie Gilbert of Matthews, Robert Morgan of Charlotte, Abby Young of Durham, Audrey Moone of Wake Forest, Akram Hauter of Wake Forest, Allyson Farina of Sanford, and Shamik Bhattacharya of Raleigh. He also recognized the Sergeants-at-Arms–Tom Burroughs, Larry Hancock, and Frances Patterson.

Sen. Hise recognized Sen. Jim Davis to present HB 243–Strengthen Opioid Misuse Prevention (STOP) Act. Sen. Jim Davis offered an amendment to the PCS pertaining to veterinarians. The amendment was adopted. Sen. Tarte moved for a favorable report to the PCS, as amended, rolled into a new PCS. The motion passed.

Sen. Krawiec chaired the remainder of the meeting, and recognized Sen. Hise to present HB 403–LME/MCO Claims Reporting/Mental Health Amdts. Sen. Hise explained each section of the bill and answered questions from committee members. Sen. Edwards moved for a favorable report to the PCS, unfavorable as to the original bill. The following members of the public spoke: Chip Baggett, Sr. VP, Associate General Counsel, NC Medical Society; Cody Hand, NC Hospital Association; Ken Lewis, Executive Director, NC Association of Health Plans; Mary Hooper, Executive Director, NC Council of Community Programs; Brian Perkins, Alliance Behavioral Health Care; Sandy Sands, Attorney for Nexsen Pruet, representing Medical Care North America; Andy Ellen, lobbyist for the NC Retail Merchants' Assoc.

After the members of the public concluded their comments, Sen. Edwards' motion was voted upon and 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
Thursday	June 15, 2017	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 243	Strengthen Opioid Misuse Prevention (STOP)Act.	Representative Murphy Representative Davis Representative Malone Representative Horn
HB 403	LME/MCO Claims Reporting/Mental Health Amdts.	Representative Dollar Representative Lambeth Representative Dobson Representative White

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

Senate Committee on Health Care
Thursday, June 15, 2017, 10:00 AM
643 Legislative Office Building

Senator Ralph Hise, Presiding

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 243	Strengthen Opioid Misuse Prevention (STOP) Act.	Representative Murphy Representative Davis Representative Malone Representative Horn
HB 403	LME/MCO Claims Reporting/Mental Health Amdts.	Representative Dollar Representative Lambeth Representative Dobson Representative White

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair
Senator Krawiec, Co-Chair
Senator Pate, Co-Chair

Thursday, June 15, 2017

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

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

HB **243** **(CS#1)** Strengthen Opioid Misuse Prevention (STOP)Act.

Draft Number:	H243-PCS40609-TY-27
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

HB **403** **(CS#1)** LME/MCO Claims Reporting/Mental Health Amdts.

Draft Number:	H403-PCS10378-TR-6
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Jim Davis will handle HB 243
Senator Ralph Hise will handle HB 403

HOUSE BILL 243: Strengthen Opioid Misuse Prevention (STOP)Act.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 14, 2017
Introduced by:	Reps. Murphy, Davis, Malone, Horn	**Prepared by:**	Augustus D. Willis Committee Counsel
Analysis of:	PCS to Third Edition H243-CSTY-16		

OVERVIEW: House Bill 243 would (i) extend the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (ii) designate certain Schedule II and III drugs as "targeted controlled substances and make changes to the laws governing the prescribing of those targeted controlled substances, (iii) clarify the allowable funds for syringe exchange programs, (iv) make changes to the statutes governing the Controlled Substance Reporting System (CSRS) database, and (v) amend language in the 2015 budget to facilitate the interstate connectivity of the CSRS database.

BILL ANALYSIS:

Part I. TITLE OF ACT

Section 1 sets forth the title of the act as the Strengthen Opioid Misuse Prevention (STOP) Act of 2017.

Part II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

G.S. 90-12.7 sets forth statutes governing the prescribing of opioid antagonists for treatment of a drug overdose. These statutes allow a practitioner to, either directly or by standing order, prescribe an opioid antagonist to a person at risk of experiencing an opiate-related overdose, or their family member, friend, or other person in a position to assist such a person. In 2016, the General Assembly expanded this to allow the State Health Director to issue prescriptions to such persons by way of a statewide standing order.

Section 2 would amend the statutes on the treatment of overdoses with opioid antagonist to (1) allow the State Health Director to name a designee to prescribe an opioid antagonist by statewide standing order, and (2) allow practitioners to either directly, or by standing order, prescribe an opioid antagonist to any governmental or nongovernmental organization for the purpose of distribution to persons at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist such a person. Any organization distributing the opioid antagonist would be required to include with it basic instruction and information on how to administer it.

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

Current law authorizes licensed physician assistants and nurse practitioners to write prescriptions so long as a supervising physician has provided written instructions for prescribing drugs and a written policy for periodic review by the physician of drugs prescribed.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Absent an emergency situation, the dispensing of Schedule II controlled substances generally requires a written prescription, made out no more than 6 months prior to the date the substance is dispensed, with an exception that no prescription is needed if the substance is dispensed directly by a practitioner to an ultimate user. Prescriptions for Schedule II controlled substances may not be refilled. Schedule III and IV controlled substances require a prescription no older than 6 months old and may not be refilled more than five times after the date of the prescription.

Section 3 would define the new term "targeted controlled substance" to include certain controlled substances currently included in Schedule II and Schedule III of the Controlled Substances Act.

Section 4 would amend the statutes authorizing physician assistants to write prescriptions by requiring a physician assistant to consult with the supervising physician prior to prescribing controlled substances included in the newly defined term "targeted controlled substance" if the therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant must consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.

Section 5 would amend the statutes authorizing nurse practitioners to write prescriptions by including the same requirements in Section 4.

Section 6 would require electronic prescriptions for all controlled substances included in the newly defined term "targeted controlled substance" unless the prescription is issued by:

- A practitioner who is dispensing directly to an ultimate user.
- A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis center or residential care facility.
- A practitioner who experiences temporary technological or electrical failure, or other extenuating circumstance that prevents the prescription from being transmitted electronically and the reason for this exception is documented in the patient's medical record.
- A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property and the reason for this exception is documented in the patient's medical record.

Prescriptions for targeted controlled substances would be limited to no more than a 5 day supply upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief immediately following a surgical procedure, in which case the practitioner may not prescribe more than a 7-day supply. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. The terms "acute pain," "chronic pain," and "surgical procedure" are defined. Dispensers are not required to verify that a practitioner falls within one of the exceptions from the requirement that all targeted controlled substances be e-prescribed and dispensers may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws. Dispensers are further immune from civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of G.S. 90-106.

Section 7 would require any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in the patient's home to provide oral and written information to the patient and the patient's family regarding the proper disposal of the controlled substance.

PART IV: CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

Section 8 would clarify language in the statute authorizing needle and syringe exchange programs to prohibit the use of State funds to purchase needles, hypodermic syringes, or other injection supplies. Non-State public funds could still be used for this purpose.

PART V: STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

The Controlled Substances Reporting System (CSRS) is a database maintained by the Department of Health and Human Services that tracks prescriptions for Schedule II through V controlled substances. Dispensers are required to report certain information on prescriptions they fill within 3 days after the prescription is delivered, but are encouraged to report such information within 24 hours. Such information is confidential and may only be accessed by certain persons for specific purposes set forth by statute. Under current law, veterinarians are not considered to be a "dispenser" for purposes of CSRS reporting requirements.

Section 9 would remove the exemption from the definition of "dispenser" for veterinarians, subjecting them to CSRS reporting requirements, define the term "pharmacy" as a person or entity who holds a valid pharmacy permit, and make other technical changes to the definitions used in the CSRS laws.

Section 10 would require dispensers to report required information by the close of the next business day after filling a prescription unless the system is temporarily not operational and the inability to report is documented in the dispenser's records. Section 10 also updates the information dispensers are required to report to include an address and telephone number for the owner of the animal in the case of a prescription dispensed for an animal. The Department of Health and Human Services would be required to assess civil penalties of up to $100 for a first violation, up to $250 for a second violation, and up to $500 for each subsequent violation, not to exceed $5,000 per pharmacy in a calendar year to pharmacies found to have failed to report required information within a reasonable period of time after being informed that such information is missing or incomplete. The PCS clarifies that pharmacies who, in good faith, attempt to report, will not be assessed a civil penalty.

Section 11 would amend the laws governing the confidentiality of CSRS data to allow the Department to notify practitioners and their respective licensing boards of prescribing behavior that increases risk of diversion of controlled substances, increases risk of harm to the patient, or is an outlier among other practitioner behavior. The PCS adds to Section 11 a requirement that the administrator of a hospital emergency department or hospital acute care facility provide the Department with lists of delegates who are authorized to receive data on behalf of providers within the facility. The lists must be submitted to the Department by December 1 of the calendar year preceding the year in which the delegation is to occur, however the lists may be updated at any time throughout the year. The Department has one week from the time it receives a list to establish the necessary delegate accounts within the CSRS.

Section 12 would add the following new sections to Article 5E of Chapter 90 of the General Statutes governing the CSRS:

- 90-113.74B: would require recipients of new or renewed pharmacist licenses to demonstrate to the NC Board of Pharmacy registration for access to the CSRS within 30 days of licensure.
- 90-113.74C: would require practitioners to review a patient's 12-month history in the CSRS prior to prescribing "targeted controlled substance" and review the patient's 12-month history in the CSRS every three months while the targeted controlled substance remains part of the patient's medical care plan. These reviews would have to be documented in the patient's medical records, along with the occasion of any CSRS outage that prevents such a review; the practitioner would be required to review the 12-month history upon restoration of the CSRS after an outage. In addition, a practitioner would be able to, but not required to, review a patient's CSRS history if: (1) the controlled substance is to be administered to the patient in a health care setting, hospital,

nursing home, outpatient dialysis facility, or residential care facility; (2) the controlled substance is for the treatment of cancer or a cancer-associated condition; or (3) the controlled substance is prescribed to a patient in hospice or palliative care. The Department would be required to conduct periodic audits of the review of the CSRS by prescribers and report to the appropriate licensing board any prescriber found to be in violation.

- 90-113.74D: would require a dispenser to review an individual's 12-month history in the CSRS prior to dispensing a targeted controlled substance whenever: 1) the dispenser believes the individual is seeking controlled substances for reasons other than treatment of a medical condition; 2) the prescriber is located outside of the usual area the dispenser serves; 3) the individual lives outside the usual area the dispenser serves; 4) the individual pays with cash when there is an insurance plan on file with the dispenser; or 5) the individual demonstrates potential misuse of a controlled substance. A dispenser would be required to withhold delivery of a prescription until verified if the dispenser believes it to be duplicative or fraudulent. Dispensers would be immune from civil or criminal liability for actions authorized by this section and failure to review the system prior to dispensing a controlled substance would not constitute medical negligence.
- 90-113.75A: would create a special revenue fund in DHHS for use in administering the CSRS.
- 90-113.75B: would require DHHS to make annual reports starting February 1, 2019, to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medicine Board, and the North Carolina Board of Pharmacy. The reports would be required to include specified data on targeted controlled substances reported to the CSRS database during the preceding calendar year.

Section 13 would amend language from the 2015 budget to direct the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to continue working toward establishing interstate connectivity for the CSRS system.

EFFECTIVE DATE: Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 would become effective July 1, 2017. The new subsections of G.S. 90-106 dealing with e-prescribing in Section 6 would become effective January 1, 2020. The new subsections of G.S. 90-106 establishing limits on initial prescriptions for acute pain in Section 6 would become effective January 1, 2018. The portion of Section 12 creating the new statutes G.S. 90-113.75A through G.S. 90-113.75C would become effective September 1, 2017. The portion of Section 10 updating the information required to be reported to the CSRS database by dispensers becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the CSRS database has the capability to record the information required. The remainder of the act would become effective when it becomes law and would apply to acts committed on or after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the CSRS database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 243
Committee Substitute Favorable 3/30/17
Third Edition Engrossed 4/10/17
PROPOSED SENATE COMMITTEE SUBSTITUTE H243-CSTY-16 [v.15]
06/12/2017 9:00:29 AM

Short Title: Strengthen Opioid Misuse Prevention (STOP)Act. (Public)

Sponsors:

Referred to:

March 6, 2017

A BILL TO BE ENTITLED

AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE CERTAIN SCHEDULE II OR III CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; REQUIRING HOSPICE AND PALLIATIVE CARE PROVIDERS TO PROVIDE EDUCATION REGARDING PROPER DISPOSAL OF CERTAIN UNUSED CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS; MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; AND REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS.

Whereas, the General Assembly recognizes the substantial impact the nationwide opioid epidemic continues to have on the State of North Carolina; and

Whereas, North Carolina has seen a 442 percent increase in overdose deaths caused by commonly prescribed opioids between 1999 and 2015; and

Whereas, the General Assembly fully recognizes the appropriate use of opioids in the treatment of acute and chronic pain; Now, therefore

The General Assembly of North Carolina enacts:

PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"**§ 90-12.7. 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:

a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

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:

1. A family member, friend, or other person.

2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director or a designee may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(3) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the 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.

(c) A pharmacist may dispense an opioid antagonist to a person ~~described in subdivision (b)(1) of this section~~ or organization pursuant to a prescription issued ~~pursuant to~~ 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.

(c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section 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. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.

(d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) 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.

(e) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.

(3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.

(4) The State Health Director acting pursuant to subsection (b) of this section.

(5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-87 reads as rewritten:

"**§ 90-87. Definitions.**

As used in this Article:

...

(26a) "Targeted controlled substance" means any controlled substance included in G.S. 90-90(1) or (2) or G.S. 90-91(d).

...."

SECTION 4. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every

90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 6. G.S. 90-106 reads as rewritten:

"**§ 90-106. Prescriptions and labeling.**

(a) ~~Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner.~~ No Schedule II substance shall be dispensed pursuant to a written or electronic prescription more than six months after the date it was prescribed.

(a1) Electronic Prescription Required; Exceptions. – Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all targeted controlled substances. This subsection does not apply to prescriptions for targeted controlled substances issued by any of the following:

(1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.

(2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis facility, or residential care facility as defined in G.S. 14-32.2.

(3) A practitioner who experiences temporary technological or electrical failure or other extenuating circumstance that prevents the prescription from being transmitted electronically, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(4) A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(a2) Verification by Dispenser Not Required. – A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a targeted controlled substance. A dispenser may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.

(a3) Limitation on Prescriptions Upon Initial Consultation for Acute Pain. – A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance for post-operative acute pain relief immediately following a surgical procedure. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E of the General Statutes, hospice facility, or residential care facility as defined in G.S. 14-32.2(c1). A practitioner who acts in accordance with the limitation on prescriptions as set forth in this subsection shall be immune from any civil liability or disciplinary action from the practitioner's occupational licensing agency for acting in accordance with this subsection.

(a4) Definitions. – As used in this subsection, the following terms have the following meanings:

(1) Acute pain. – Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

(2) Chronic pain. – Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(3) Surgical procedure. – A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

(a5) Dispenser Immunity. – A dispenser shall be immune from any civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of this section.

(b) In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.

(c) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.

(d) No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.

(e) No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.

(f) No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.

(g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.

(h) A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

(i) A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 7. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.**

Any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall, at the commencement of treatment, provide oral and written information

to the patient and his or her family regarding the proper disposal of such targeted controlled substances. This information shall include the availability of permanent drop boxes or periodic "drug take-back" events that allow for the safe disposal of controlled substances such as those permanent drop boxes and events that may be identified through North Carolina Operation Medicine Drop."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

"(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No ~~public~~ State funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

SECTION 9. G.S. 90-113.72 reads as rewritten:

"**§ 90-113.72. Definitions.**

The following definitions apply in this Article:

(1) ~~"Commission" means the~~ Commission. – The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(2) ~~"Controlled substance" means a~~ Controlled substance. – A controlled substance as defined in G.S. 90-87(5).

(3) ~~"Department" means the~~ Department. – The Department of Health and Human Services.

(4) ~~"Dispenser" means a~~ Dispenser. – A person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:

a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

b. Repealed by Session Laws 2013-152, s. 1, effective January 1, 2014, and applicable to prescriptions delivered on or after that date.

c. A wholesale distributor of a Schedule II through V controlled substance.

~~d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.~~

(4a) Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A.

(5) ~~"Ultimate user" means a~~ Ultimate user. – A person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the person's own use, for the use of a member of the person's household, or for the use of an animal owned or controlled by the person or by a member of the person's household."

SECTION 10. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting ~~system.~~system; civil penalties for failure to properly report.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser who is unable to submit prescription

information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than ~~the close of business three business days after the day when the prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hours~~the close of the next business day after the prescription is delivered; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system. In the event the dispenser is unable to report the information within the time frame required by this section because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the dispenser's records. Once the electrical or technological failure has been resolved, the dispenser shall promptly report the information.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.

(2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:

a. Full address, including city, state, and zip code,

b. Telephone number, and

c. Date of birth.

(2a) If the controlled substance is dispensed for an animal, the following information:

a. Name of the animal,

b. Full address, including city, state, and zip code of the owner of the animal, and

c. Telephone number of the owner of the animal.

(3) The date the prescription was written.

(4) The date the prescription was filled.

(5) The prescription number.

(6) Whether the prescription is new or a refill.

(7) Metric quantity of the dispensed drug.

(8) Estimated days of supply of dispensed drug, if provided to the dispenser.

(9) National Drug Code of dispensed drug.

(10) Prescriber's DEA number.

(11) Method of payment for the prescription.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than one hundred dollars ($100.00) for a first violation, two hundred fifty dollars ($250.00) for a second violation, and five hundred dollars

($500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of five thousand dollars ($5,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. A pharmacy acting in good faith that attempts to report the information required by this section shall not be assessed any civil penalty. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74 reads as rewritten:

"...

(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:

...

(1a) Notify practitioners and their respective licensing boards of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

...

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

(1) Persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients. A person authorized to receive data pursuant to this paragraph may delegate the authority to receive the data to other persons working under his or her direction and supervision, provided the Department approves this delegation.

a. The administrator of a hospital emergency department or hospital acute care facility shall provide the Department with a list of prescribers who are authorized to prescribe controlled substances for the purpose of providing medical care for patients of the hospital emergency department or hospital acute care facility and a list of delegates who are authorized to receive data on behalf of the providers listed. The administrator acting under this paragraph shall submit the lists to the Department no later than December 1 of the calendar year preceding the year during which the delegates are to receive data and may provide updated lists at any time during the course of the year. Within one week of receiving the initial or updated lists described in this paragraph, the Department shall establish all of the delegate accounts necessary to enable each delegate listed by the administrator of the hospital emergency department or hospital acute care facility to receive data on behalf of the listed prescribers. Delegations made pursuant to this paragraph are valid during the calendar year for which submitted by the administrator.

..."

SECTION 12. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"**§ 90-113.74B. Mandatory dispenser registration for access to controlled substances reporting system; exception.**

(a) Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he

or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

(b) This section does not apply to a licensee employed in a pharmacy practice setting where a Schedule II, III, or IV controlled substance will not be dispensed.

"**§ 90-113.74C. Practitioner use of controlled substances reporting system; mandatory reporting of violations.**

(a) Prior to initially prescribing a targeted controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the targeted controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the targeted controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient and the review shall be documented in the patient's medical record.

(b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a targeted controlled substance to the patient in any of the following circumstances:

(1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, outpatient dialysis facility, or residential care facility as defined in G.S. 14-32.2.

(2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.

(3) The controlled substance is prescribed to a patient in hospice care or palliative care.

(c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

"**§ 90-113.74D. Dispenser use of controlled substances reporting system.**

(a) Prior to dispensing a targeted controlled substance, a dispenser shall review the information in the controlled substances reporting system pertaining to the patient for the preceding 12-month period and document this review under any of the following circumstances:

(1) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user's existing medical condition.

(2) The prescriber is located outside of the usual geographic area served by the dispenser.

(3) The ultimate user resides outside of the usual geographic area served by the dispenser.

(4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser.

(5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following:

a. Over-utilization of the controlled substance.

b. Requests for early refills.

c. Utilization of multiple prescribers.

d. An appearance of being overly sedated or intoxicated upon presenting a prescription.

e. A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks.

(b) If a dispenser has reason to believe a prescription for a targeted controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate.

(c) A dispenser shall be immune from any civil or criminal liability for actions authorized by this section. Failure to review the system in accordance with subsection (a) of this section shall not constitute medical negligence.

"**§ 90-113.75A. Creation of Controlled Substances Reporting System Fund.**

(a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.

(b) The Fund shall consist of the following:

(1) Any moneys appropriated to the Fund by the General Assembly.

(2) Any moneys received from State, federal, private, or other sources for deposit into the Fund.

(c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"**§ 90-113.75B. Annual report to General Assembly and licensing boards.**

Annually on February 1, beginning February 1, 2019, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about targeted controlled substances reported to the system during the preceding calendar year:

(1) The total number of prescriptions dispensed, broken down by Schedule.

(2) Demographics about the ultimate users to whom prescriptions were dispensed.

(3) Statistics regarding the number of pills dispensed per prescription.

(4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.

(5) The number of ultimate users to whom a prescription was dispensed in more than one county.

(6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors, surgeons, palliative care practitioners, oncologists and other practitioners specializing in oncology, pain management practitioners, practitioners who specialize in hematology, including the treatment of sickle cell disease, and practitioners who

specialize in treating substance use disorder shall be treated as distinct categories of practitioners.

(7) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

SECTION 13.(a) Section 12F.16(h) of Session Law 2015-241 reads as rewritten:

"**SECTION 12F.16.(h)** ~~DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect. The Department shall request forty thousand thirty-five dollars ($40,035) to establish the initial interface for PMP InterConnect and thirty thousand dollars ($30,000) for two years of ongoing service, maintenance, and support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.~~The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System established under G.S. 90-113.73."

SECTION 13.(b) Section 12F.16(i)(3) of Session Law 2015-241 reads as rewritten:

"(3) ~~For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to establish the initial interface for PMP InterConnect, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.~~The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System established under G.S. 90-113.73."

PART VI. EFFECTIVE DATE

SECTION 14.(a) Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 of this act become effective July 1, 2017.

SECTION 14.(b) Subsections (a), (a1), and (a2) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2020.

SECTION 14.(c) Subsections (a3) and (a4) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2018.

SECTION 14.(d) G.S. 90-113.75A and G.S. 90-113.75B, as enacted by Section 12 of this act, become effective September 1, 2017.

SECTION 14.(e) Subsection (b) of G.S. 90-113.73(b), as enacted by Section 10 of this act, is effective when it becomes law. The remainder of Section 10 of this act becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the Controlled Substance Reporting System (CSRS) database has the capability to record the information described in Section 10 of this act. The Chief Information Officer shall notify the Revisor of Statutes once the CSRS database has the capability to record the information described in Section 10 of this act.

SECTION 14.(f) The remainder of this act is effective when it becomes law and applies to acts committed 30 days after the date the State Chief Information Officer notifies the

Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H 3

HOUSE BILL 243*
Committee Substitute Favorable 3/30/17
Third Edition Engrossed 4/10/17

Short Title: Strengthen Opioid Misuse Prevention (STOP)Act. (Public)

Sponsors:

Referred to:

March 6, 2017

A BILL TO BE ENTITLED

AN ACT STRENGTHENING OPIOID MISUSE PREVENTION BY EXTENDING STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS; REQUIRING SUPERVISING PHYSICIANS TO PERSONALLY CONSULT WITH PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS WHO PRESCRIBE CERTAIN SCHEDULE II OR III CONTROLLED SUBSTANCES FOR LONG-TERM USE; REQUIRING ELECTRONIC PRESCRIBING OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; ESTABLISHING MAXIMUM LIMITS FOR INITIAL PRESCRIPTIONS OF CERTAIN SCHEDULE II AND III CONTROLLED SUBSTANCES; REQUIRING HOSPICE AND PALLIATIVE CARE PROVIDERS TO PROVIDE EDUCATION REGARDING PROPER DISPOSAL OF CERTAIN UNUSED CONTROLLED SUBSTANCES; CLARIFYING ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS; REQUIRING VETERINARIAN PARTICIPATION IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM; ESTABLISHING CIVIL PENALTIES FOR PHARMACIES THAT EMPLOY DISPENSERS WHO IMPROPERLY REPORT INFORMATION TO THE CONTROLLED SUBSTANCES REPORTING SYSTEM (CSRS); EXPANDING THE ROLE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) IN USING CSRS DATA TO DETECT AND PREVENT FRAUD AND MISUSE; MANDATING DISPENSER REGISTRATION FOR ACCESS TO THE CSRS; MANDATING DISPENSER AND PRACTITIONER USE OF THE CSRS; REQUIRING DHHS TO REPORT PRACTITIONERS WHO FAIL TO PROPERLY USE THE CSRS; CREATING A SPECIAL REVENUE FUND TO SUPPORT THE CSRS; AND REQUIRING AN ANNUAL REPORT FROM DHHS ON THE CSRS.

The General Assembly of North Carolina enacts:

PART I. TITLE OF ACT

SECTION 1. This act shall be known and may be cited as the "Strengthen Opioid Misuse Prevention Act of 2017" or the "STOP Act."

PART II. EXTEND STANDING ORDERS FOR OPIOID ANTAGONIST TO COMMUNITY HEALTH GROUPS

SECTION 2. G.S. 90-12.7 reads as rewritten:

"**§ 90-12.7. 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:

a. The person seeking the opioid antagonist is at risk of experiencing an opiate-related overdose.

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:

1. A family member, friend, or other person.

2. In the position to assist a person at risk of experiencing an opiate-related overdose.

(2) The State Health Director or a designee may prescribe an opioid antagonist pursuant to subdivision (1) of this subsection by means of a statewide standing order.

(3) A practitioner acting in good faith and exercising reasonable care may directly or by standing order prescribe an opioid antagonist to any governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors, for the purpose of distributing, through its agents, the 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.

(c) A pharmacist may dispense an opioid antagonist to a person ~~described in subdivision (b)(1) of this section~~ or organization pursuant to a prescription issued ~~pursuant to~~ 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.

(c1) A governmental or nongovernmental organization, including a local health department, a law enforcement agency, or an organization that promotes scientifically proven ways of mitigating health risks associated with substance use disorders and other high-risk behaviors may, through its agents, distribute an opioid antagonist obtained pursuant to a prescription issued in accordance with subdivision (3) of subsection (b) of this section 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. An organization, through its agents, shall include with any distribution of an opioid antagonist pursuant to this subsection basic instruction and information on how to administer the opioid antagonist.

(d) A person who receives an opioid antagonist that was prescribed pursuant to subsection (b) of this section or distributed pursuant to subsection (c1) 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.

(e) All of the following individuals are immune from any civil or criminal liability for actions authorized by this section:

(1) Any practitioner who prescribes an opioid antagonist pursuant to subsection (b) of this section.

(2) Any pharmacist who dispenses an opioid antagonist pursuant to subsection (c) of this section.

(3) Any person who administers an opioid antagonist pursuant to subsection (d) of this section.

(4) The State Health Director acting pursuant to subsection (b) of this section.

(5) Any organization, or agent of the organization, that distributes an opioid antagonist pursuant to subsection (c1) of this section."

PART III. IMPROVE OPIOID PRESCRIBING PRACTICES

SECTION 3. G.S. 90-87 reads as rewritten:

"**§ 90-87. Definitions.**

As used in this Article:

...

(26a) "Targeted controlled substance" means any controlled substance included in G.S. 90-90(1) or (2) or G.S. 90-91(d).

...."

SECTION 4. G.S. 90-18.1(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the physician assistant shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the physician assistant shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 5. G.S. 90-18.2(b) is amended by adding a new subdivision to read:

"(5) If the prescription is for a targeted controlled substance as defined in Article 5 of Chapter 90 of the General Statutes and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days, the nurse practitioner shall personally consult with the supervising physician prior to prescribing the targeted controlled substance to verify that the prescription is medically appropriate for the patient. For as long as a targeted controlled substance is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient."

SECTION 6. G.S. 90-106 reads as rewritten:

"**§ 90-106. Prescriptions and labeling.**

(a) ~~Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedule II of this Article may be dispensed without the written prescription of a practitioner.~~ No Schedule II substance shall be dispensed

pursuant to a written or electronic prescription more than six months after the date it was prescribed.

(a1) Electronic Prescription Required; Exceptions. – Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all targeted controlled substances. This subsection does not apply to prescriptions for targeted controlled substances issued by any of the following:

(1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.

(2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, or residential care facility as defined in G.S. 14-32.2.

(3) A practitioner who experiences temporary technological or electrical failure or other extenuating circumstance that prevents the prescription from being transmitted electronically, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(4) A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property, provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(a2) Verification by Dispenser Not Required. – A dispenser is not required to verify that a practitioner properly falls under one of the exceptions specified in subsection (a1) of this section prior to dispensing a targeted controlled substance. A dispenser may continue to dispense targeted controlled substances from valid written, oral, or facsimile prescriptions that are otherwise consistent with applicable laws.

(a3) Limitation on Prescriptions Upon Initial Consultation for Acute Pain. – A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance for post-operative acute pain relief immediately following a surgical procedure. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E of the General Statutes, hospice facility, or residential care facility as defined in G.S. 14-32.2(c1).

(a4) Pain Management Agreement Plan for Extended Therapeutic Use of a Targeted Controlled Substance. – If a prescription is for a targeted controlled substance and therapeutic use of the targeted controlled substance will or is expected to exceed a period of 60 days, the practitioner prescribing the targeted controlled substance shall execute a pain management agreement with the patient that includes the following elements:

(1) Agreement date.

(2) Patient name and practitioner name.

(3) Relevant diagnosis/diagnoses.

(4) Name of targeted drug(s), dosage amount, and frequency of administration.

(5) Refill policy.

(6) Other pain management therapies to be used.

(7) Required follow-up with prescribing practitioner.

(8) Random drug testing policy.

(9) Use of Controlled Substances Reporting System by prescribing practitioner.

(10) Acknowledgement by patient that targeted drug(s) cannot be prescribed by other practitioners while the agreement is in force.

(11) Policy for agreement termination.

(a5) Definitions. – As used in this subsection, the following terms have the following meanings:

(1) Acute pain. – Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

(2) Chronic pain. – Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(3) Surgical procedure. – A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human tissue by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

(a6) Dispenser Immunity. – A dispenser shall be immune from any civil or criminal liability or disciplinary action from the Board of Pharmacy for dispensing a prescription written by a prescriber in violation of this section.

(b) In emergency situations, as defined by rule of the Commission, Schedule II drugs may be dispensed upon oral prescription of a practitioner, reduced promptly to writing and filed by the dispensing agent. Prescriptions shall be retained in conformity with the requirements of G.S. 90-104. No prescription for a Schedule II substance may be refilled.

(c) Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance included in Schedules III or IV, except paregoric, U.S.P., as provided in G.S. 90-91(e)1, may be dispensed without a prescription, and oral prescriptions shall be promptly reduced to writing and filed with the dispensing agent. Such prescription may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription.

(d) No controlled substance included in Schedule V of this Article or paregoric, U.S.P., may be distributed or dispensed other than for a medical purpose.

(e) No controlled substance included in Schedule VI of this Article may be distributed or dispensed other than for scientific or research purposes by persons registered under, or permitted by, this Article to engage in scientific or research projects.

(f) No controlled substance shall be dispensed or distributed in this State unless such substance shall be in a container clearly labeled in accord with regulations lawfully adopted and published by the federal government or the Commission.

(g) When a copy of a prescription for a controlled substance under this Article is given as required by G.S. 90-70, such copy shall be plainly marked: "Copy – for information only." Copies of prescriptions for controlled substances shall not be filled or refilled.

(h) A pharmacist dispensing a controlled substance under this Article shall enter the date of dispensing on the prescription order pursuant to which such controlled substance was dispensed.

(i) A manufacturer's sales representative may distribute a controlled substance as a complimentary sample only upon the written request of a practitioner. Such request must be made on each distribution and must contain the names and addresses of the supplier and the

requester and the name and quantity of the specific controlled substance requested. The manufacturer shall maintain a record of each such request for a period of two years."

SECTION 7. Article 5 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-106.3. Disposal of residual pain prescriptions following death of hospice or palliative care patient.**

Any hospice or palliative care provider who prescribes a targeted controlled substance to be administered to a patient in his or her home for the treatment of pain as part of in-home hospice or palliative care shall, at the commencement of treatment, provide oral and written information to the patient and his or her family regarding the proper disposal of such targeted controlled substances. This information shall include the availability of permanent drop boxes or periodic "drug take-back" events that allow for the safe disposal of controlled substances such as those permanent drop boxes and events that may be identified through North Carolina Operation Medicine Drop."

PART IV. CLARIFY ALLOWABLE FUNDS FOR SYRINGE EXCHANGE PROGRAMS

SECTION 8. G.S. 90-113.27(b)(2) reads as rewritten:

"(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No ~~public~~ State funds may be used to purchase needles, hypodermic syringes, or other injection supplies."

PART V. STRENGTHEN CONTROLLED SUBSTANCES REPORTING SYSTEM

SECTION 9. G.S. 90-113.72 reads as rewritten:

"**§ 90-113.72. Definitions.**

The following definitions apply in this Article:

(1) ~~"Commission" means the~~ Commission. – The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services established under Part 4 of Article 3 of Chapter 143B of the General Statutes.

(2) ~~"Controlled substance" means a~~ Controlled substance. – A controlled substance as defined in G.S. 90-87(5).

(3) ~~"Department" means the~~ Department. – The Department of Health and Human Services.

(4) ~~"Dispenser" means a~~ Dispenser. – A person who delivers a Schedule II through V controlled substance to an ultimate user in North Carolina, but does not include any of the following:

a. A licensed hospital or long-term care pharmacy that dispenses such substances for the purpose of inpatient administration.

b. Repealed by Session Laws 2013-152, s. 1, effective January 1, 2014, and applicable to prescriptions delivered on or after that date.

c. A wholesale distributor of a Schedule II through V controlled substance.

~~d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.~~

(4a) Pharmacy. – A person or entity holding a valid pharmacy permit pursuant to G.S. 90-85.21 or G.S. 90-85.21A.

(5) ~~"Ultimate user" means a~~ Ultimate user. – A person who has lawfully obtained, and who possesses, a Schedule II through V controlled substance for the person's own use, for the use of a member of the person's household,

or for the use of an animal owned or controlled by the person or by a member of the person's household."

SECTION 10. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting ~~system.~~system; civil penalties for failure to properly report.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission. The Department may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than ~~the close of business three business days after the day when the prescription was delivered, beginning the next day after the delivery date; however, dispensers are encouraged to report the information no later than 24 hours~~the close of the next business day after the prescription is delivered; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system. In the event the dispenser is unable to report the information within the time frame required by this section because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the dispenser's records. Once the electrical or technological failure has been resolved, the dispenser shall promptly report the information.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.

(2) The name of the patient for whom the controlled substance is ~~being~~ dispensed, ~~and the patient's:~~ or if the controlled substance is dispensed for an animal, the name of the owner of the animal and the following information of the patient or owner:

a. Full address, including city, state, and zip code,

b. Telephone number, and

c. Date of birth.

(3) The date the prescription was written.

(4) The date the prescription was filled.

(5) The prescription number.

(6) Whether the prescription is new or a refill.

(7) Metric quantity of the dispensed drug.

(8) Estimated days of supply of dispensed drug, if provided to the dispenser.

(9) National Drug Code of dispensed drug.

(10) Prescriber's DEA number.

(11) Method of payment for the prescription.

(12) If the prescriber is a physician assistant or a nurse practitioner, the name of that individual's supervising physician.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the

ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than one hundred dollars ($100.00) for a first violation, two hundred fifty dollars ($250.00) for a second violation, and five hundred dollars ($500.00) for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of five thousand dollars ($5,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed."

SECTION 11. G.S. 90-113.74(b1) reads as rewritten:

"(b1) The Department may review the prescription information data in the controlled substances reporting system and upon review may:

...

(1a) Notify practitioners and their respective licensing boards of prescribing behavior that (i) increases risk of diversion of controlled substances, (ii) increases risk of harm to the patient, or (iii) is an outlier among other practitioner behavior.

...."

SECTION 12. Article 5E of Chapter 90 of the General Statutes is amended by adding new sections to read:

"**§ 90-113.74B. Mandatory dispenser registration for access to controlled substances reporting system; exception.**

(a) Within 30 days after obtaining an initial or renewal license to practice pharmacy, the licensee shall demonstrate to the satisfaction of the North Carolina Board of Pharmacy that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the Board of Pharmacy to suspend or revoke the license.

(b) This section does not apply to a licensee employed in a pharmacy practice setting where a Schedule II, III, or IV controlled substance will not be dispensed.

"**§ 90-113.74C. Practitioner use of controlled substances reporting system; mandatory reporting of violations.**

(a) Prior to initially prescribing a targeted controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the targeted controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the targeted controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient and the review shall be documented in the patient's medical record.

(b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a targeted controlled substance to the patient in any of the following circumstances:

(1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, or residential care facility as defined in G.S. 14-32.2.

(2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.

(3) The controlled substance is prescribed to a patient in hospice care or palliative care.

(c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

"**§ 90-113.74D. Dispenser use of controlled substances reporting system.**

(a) Prior to dispensing a targeted controlled substance, a dispenser shall review the information in the controlled substances reporting system pertaining to the patient for the preceding 12-month period and document this review under any of the following circumstances:

(1) The dispenser has a reasonable belief that the ultimate user may be seeking a targeted controlled substance for any reason other than the treatment of the ultimate user's existing medical condition.

(2) The prescriber is located outside of the usual geographic area served by the dispenser.

(3) The ultimate user resides outside of the usual geographic area served by the dispenser.

(4) The ultimate user pays for the prescription with cash when the patient has prescription insurance on file with the dispenser.

(5) The ultimate user demonstrates potential misuse of a controlled substance by any one or more of the following:

a. Over-utilization of the controlled substance.

b. Requests for early refills.

c. Utilization of multiple prescribers.

d. An appearance of being overly sedated or intoxicated upon presenting a prescription.

e. A request by an unfamiliar ultimate user for an opioid drug by a specific name, street name, color, or identifying marks.

(b) If a dispenser has reason to believe a prescription for a targeted controlled substance is fraudulent or duplicative, the dispenser shall withhold delivery of the prescription until the dispenser is able to contact the prescriber and verify that the prescription is medically appropriate.

(c) A dispenser shall be immune from any civil or criminal liability for actions authorized by this section. Failure to review the system in accordance with subsection (a) of this section shall not constitute medical negligence.

"**§ 90-113.75A. Creation of Controlled Substances Reporting System Fund.**

(a) The Controlled Substances Reporting System Fund is created within the Department as a special revenue fund. The Department shall administer the Fund. The Department shall use the Fund only for operation of the controlled substances reporting system and to carry out the provisions of this Article.

(b) The Fund shall consist of the following:

(1) Any moneys appropriated to the Fund by the General Assembly.

(2) Any moneys received from State, federal, private, or other sources for deposit into the Fund.

(c) All interest that accrues to the Fund shall be credited to the Fund. Any balance remaining in the Fund at the end of any fiscal year shall remain in the Fund and shall not revert to the General Fund.

"**§ 90-113.75B. Annual report to General Assembly and licensing boards.**

Annually on February 1, beginning February 1, 2019, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Podiatry Examiners, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, and the North Carolina Board of Pharmacy on data reported to the controlled substances reporting system. The report shall include at least all of the following information about targeted controlled substances reported to the system during the preceding calendar year:

(1) The total number of prescriptions dispensed, broken down by Schedule.

(2) Demographics about the ultimate users to whom prescriptions were dispensed.

(3) Statistics regarding the number of pills dispensed per prescription.

(4) The number of ultimate users who were prescribed a controlled substance by two or more practitioners.

(5) The number of ultimate users to whom a prescription was dispensed in more than one county.

(6) The categories of practitioners prescribing controlled substances and the number of prescriptions authorized by each category of practitioner. For the purpose of this subdivision, medical doctors, surgeons, palliative care practitioners, oncologists and other practitioners specializing in oncology, pain management practitioners, practitioners who specialize in hematology, including the treatment of sickle cell disease, and practitioners who specialize in treating substance use disorder shall be treated as distinct categories of practitioners.

(7) Any other data deemed appropriate and requested by the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, the North Carolina Dental Board, the North Carolina Veterinary Medical Board, or the North Carolina Board of Pharmacy."

SECTION 13.(a) Section 12F.16(h) of Session Law 2015-241 reads as rewritten:

"**SECTION 12F.16.(h)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DHHS), shall continue to work toward establishing interstate connectivity for the Controlled Substances Reporting System (CSRS) established under G.S. 90-113.73. DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish ~~the connection to PMP InterConnect.~~interstate connectivity for the CSRS. The Department shall request forty thousand thirty-five dollars ($40,035) to establish ~~the initial interface for PMP InterConnect~~interstate connectivity for the CSRS and thirty thousand dollars ($30,000) for two years of ongoing interstate connectivity service, maintenance, and ~~support for PMP InterConnect in order to create interstate connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.~~support."

SECTION 13.(b) Section 12F.16(i)(3) of Session Law 2015-241 reads as rewritten:

"(3) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to establish ~~the initial interface for PMP InterConnect,~~ interstate connectivity for the CSRS, as required by subdivision (2) of subsection (f) of this section. ~~This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.~~ Upon receipt of any grant funding used for this purpose or upon identification of other allowable receipts for this purpose, DHHS shall reimburse the General Fund for the costs associated with establishing interstate connectivity for the CSRS. The reimbursement amount shall be limited to the amount of any grant funding received by DHHS for this purpose plus the amount of any allowable receipts used by DHHS for this purpose, but shall not exceed the amount of the nonrecurring funds appropriated in this section."

PART VI. EFFECTIVE DATE

SECTION 14.(a) Sections 1, 2, 3, 4, 5, 7, 8, 11, and 13 of this act become effective July 1, 2017.

SECTION 14.(b) Subsections (a), (a1), and (a2) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2020.

SECTION 14.(c) Subsections (a3), (a4), and (a5) of G.S. 90-106, as amended by Section 6 of this act, become effective January 1, 2018.

SECTION 14.(d) G.S. 90-113.75A and G.S. 90-113.75B, as enacted by Section 12 of this act, become effective September 1, 2017.

SECTION 14.(e) Subsection (b) of G.S. 90-113.73(b), as enacted by Section 10 of this act, is effective when it becomes law. The remainder of Section 10 of this act becomes effective 30 days after the date the Chief Information Officer notifies the Revisor of Statutes that the Controlled Substance Reporting System (CSRS) database has the capability to record the information described in Section 10 of this act. The Chief Information Officer shall notify the Revisor of Statutes once the CSRS database has the capability to record the information described in Section 10 of this act.

SECTION 14.(f) The remainder of this act is effective when it becomes law and applies to acts committed 30 days after the date the State Chief Information Officer notifies the Revisor of Statutes that (i) the upgrades to the Controlled Substances Reporting System (CSRS) database described in subdivisions (1) and (2) of subsection (a) of Section 12F.7 of S.L. 2016-94 have been completed and (ii) the upgraded CSRS database is fully operational within the Department of Information Technology and connected to the statewide health information exchange.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 243*

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

H243-ATY-34 [v.3]

Amends Title [NO]
Third Edition

Date 6/15/17 ,2017

Senator J W Davis

moves to amend the bill on page 4, lines 25-26 by inserting the following between those lines:

"(5) A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.";

and on page 6, lines 36-37 by rewriting the lines to read:

"d. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes."

and on page 7, lines 25-30 by deleting those lines;

and on page 11, line 33 by rewriting the line to read:

"**SECTION 14.** The Department of Health and Human Services shall conduct a study, in consultation with the Office of the Attorney General and the North Carolina Veterinary Medical Board, on how to implement the provisions of this act pertaining to electronic prescriptions and the submission of data to the Controlled Substances Reporting System as they relate to the practice of veterinary medicine. The Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services no later than February 1, 2018.";

and by renumbering the remaining sections accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

H243-ATY-34-V-3

HOUSE BILL 403: LME/MCO Claims Reporting/Mental Health Amdts.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 14, 2017
Introduced by:	Reps. Dollar, Lambeth, Dobson, White	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Second Edition H403-CSTR-6		

OVERVIEW: The PCS to House Bill 403 would make various modifications to laws pertaining to local management entities/managed care organizations (LME/MCOs) and to the Medicaid program, as follows:

- ***Part I modifies certain requirements pertaining to LME/MCOs, which manage the provision of publicly-funded behavioral health services throughout the State.***
- ***Part II modifies the Medicaid transformation legislation, enacted in 2015 and amended in 2016, requiring transition of the Medicaid delivery system to capitated contracts with Prepaid Health Plans.***
- ***Part III requires the Department of Health and Human Services (DHHS) to notify the General Assembly every time DHHS submits a Medicaid State Plan amendment for federal approval and every time DHHS decides not to submit a proposed State Plan amendment that was posted to DHHS's website.***
- ***Part IV amends the statutes that govern Medicaid enrollees' appeals and grievances related to actions taken by LME/MCOs to make these statutes conform to changes in the Medicaid federal regulations that recently took effect.***

PART I. LME/MCO MODIFICATIONS

CURRENT LAW/BACKGROUND: S.L. 2011-264 (HB 916), as amended by Section 13, S.L. 2012-151 (SB 191), directed the Department of Health and Human Services (DHHS) to proceed with statewide restructuring of management responsibilities for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders, through the statewide expansion of the Section 1915(b)/(c) Medicaid Waiver and the operation of the waiver by regional LME/MCOs. As directed in the law, statewide expansion was completed by July 2013. LME/MCO operations are governed by Chapter 122C of the General Statutes.

Originally, 11 LME/MCOs were formed, and those have consolidated to the 7 LME/MCOs that currently exist in the State, which include Vaya Health, Partners Behavioral Health, Cardinal Innovations Healthcare Solutions, Sandhills Center, Alliance Behavioral Health, Eastpointe, and Trillium Health Resources.

LME/MCOs originated from area authorities, county programs, and consolidated human services agencies, which later became local management entities (LMEs). Today, all LME/MCOs are structured

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

as area authorities, and county programs and consolidated human services agencies no longer operate. The terms "area authority," "LME," and "LME/MCO" all refer to the same entities.

The LME/MCOs manage funding from 4 primary sources: State-only (single-stream) funding, State and federal Medicaid funds, federal block grant funds, and county funds.

BILL ANALYSIS: **Part I** of the PCS amends several sections of Chapter 122C, The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, and other provisions of law pertaining to LME/MCOs.

Section 1 directs that on the date when Medicaid capitated contracts with Prepaid Health Plans (PHPs) begin: (1) PHPs shall manage all publicly-funded behavioral health services, (2) the LME/MCOs shall be dissolved, and (3) all remaining LME/MCO assets shall be transferred to DHHS and used to satisfy LME/MCO liabilities or to pay for the cost of contracts with PHPs. If the assets transferred to DHHS are insufficient to cover the LME/MCOs' liabilities, the State shall satisfy the liabilities or arrange to transfer the liabilities to the PHPs.

Section 2 of the PCS requires DHHS to specify a standardized electronic format that all LME/MCOs must use to submit data to DHHS regarding claims billed for Medicaid and State-funded services and to work with LME/MCOs to ensure the success of the process for submitting this data. This section lists permissible uses of the data by DHHS and requires DHHS to report on the status of this requirement by February 1, 2018.

Section 3 of the PCS amends the statute pertaining to the powers and duties of the Secretary of DHHS relevant to the mental health, developmental disabilities, and substance abuse services system to require DHHS to use contracts with LME/MCOs for the management of State-only funding, federal block grant funding, and Medicaid funding that include quality outcome measures for covered services. This section is effective January 1, 2018 and applies to contracts entered into on or after the bill becomes law.

Section 4 of the PCS amends various definitions pertaining to the State's mental health, developmental disabilities, and substance abuse services system, including amending the definition of "area director" to clarify that the term refers to the administrative head of the LME/MCO, regardless of the title that individual uses. This section amends other definitions for clarity and to remove obsolete references.

Section 5 of the PCS amends the statute pertaining to the powers and duties of an area authority to codify certain powers and duties that were enacted in uncodified language in S.L. 2011-264.

Section 6 of the PCS amends the statute pertaining to processes that may occur when an area authority is not providing minimally adequate services to specify that those processes may apply when the Secretary of DHHS determines that an area authority or area director has failed to comply with any requirement of State or federal law, rule, or regulation, or any requirement of the area authority's contract with DHHS. The process allows the Secretary to withhold funding from an area authority or assume control of an area authority's management functions after giving the area authority notice and an opportunity to be heard. If the Secretary either withholds funding or assumes control of management functions, the Secretary must develop and oversee a corrective action plan for the area authority. If the area authority does not comply with the corrective action plan, the Secretary, upon notice to the area authority, may appoint a caretaker board and terminate the area director.

Section 7 of the PCS amends the statute pertaining to the area authorities' responsibilities related to their funding to specify that area authorities shall not expend any resources on alcohol, first-class airfare, charter flights, holiday parties or similar social gatherings, or meetings outside the State.

Section 8 of the PCS requires the Office of State Human Resources (OSHR), in collaboration with the Secretary of DHHS and the LME/MCO boards, to take certain actions to revise the job description and salary range for LME/MCO area directors. **Section 8(b)** imposes the following requirements:

- Requires OSHR to update the job description for area directors by September 1, 2017.
- Requires OSHR to recommend a revised salary range to the State Human Resources Commission by December 1, 2017. The recommendation must be based upon a market compensation study of public and not-for-profit organizations nationwide with similar functions to the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographical service areas.
- Requires the State Human Resources Commission to revise the salary range based on this recommendation by March 1, 2018.

Section 8(c) voids the current salary range for area directors and prohibits area authorities from increasing any area director's salary until the new salary range is established, except that vacant area director positions may be filled. **Section 8(d)** requires LME/MCO boards to reestablish the salary for their area director upon the establishment of the new salary range. This requirement would apply to contracts with area directors beginning on or after the date that this act becomes law. **Section 8(e)** authorizes OSHR to recommend to the State Human Resources Commission revisions the salary range for area directors until LME/MCOs are dissolved under **Section 1** of the PCS. Recommendations must be based a market compensation study meeting the same criteria as required for **Section 8(b)**.

Section 9 of the PCS removes obsolete references from Chapter 122C.

EFFECTIVE DATE: Part I of the PCS would be effective when it becomes law.

PART II. MEDICAID TRANSFORMATION MODIFICATIONS

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 (per person per month) contracts with Prepaid Health Plans (PHPs) under an 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS).

BILL ANALYSIS: **Part II** of the PCS makes various changes to the Medicaid transformation legislation, as follows:

- Clarifies rule-making authority pertaining to licensure of PHPs and other aspects of Medicaid transformation.
- Clarifies the definitions of the terms "commercial plan" and "provider-led entity" (PLE).
- Eliminates the exclusion of behavioral health services from PHP coverage for four years after capitated contracts begin.
- Eliminates the exclusion of dental services from PHP coverage.
- Adds an exclusion for the coverage of eyeglasses from PHP coverage.

- Requires Medicare and Medicaid dually-eligible recipients to be covered by PHPs beginning two years after captitated contracts begin, and allows their enrollment to be phased in over a period of up to two years.
- Adds to the list of populations excluded from PHP coverage recipients who are enrolled under the Medicaid Family Planning program and recipients who are inmates of prisons.
- Changes the number of statewide PHP contracts that may be awarded from three to at least three but no more than five.
- Changes the number of regional PLE contracts that may be awarded from 12 to four and allows DHHS to specify any number of regions (current legislation requires six regions).
- Replaces the requirement that PHPs must comply with Chapter 58 of the General Statutes with a requirement to comply with recently-amended federal Medicaid managed care regulations.
- Clarifies that DHHS is authorizes to submit modifications to the 1115 waiver submission to CMS and requires notice to the General Assembly of the submission of any modifications.
- Requires PHPs and hospitals to negotiate mutually acceptable rates.
- Requires that PHP payments to hospitals may not exceed 125% of the fee-for-service rate unless a higher rate is approved by DHHS.
- Requires providers enrolling or reenrolling as a Medicaid provider to agree to accept 90% of the Medicaid fee-for-service rate for the services they provide to PHP enrollees if the provider has been offered a contract with the PHP but is not under a contract with the PHP or has been excluded from a contract with the PHP for failing to meet quality standards.

EFFECTIVE DATE: **Part II** of the PCS is effective when it becomes law.

PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS

CURRENT LAW: G.S. 108A-54.1A(d) requires DHHS to post amendments to the Medicaid State Plan, including Medicaid waivers and waiver amendments, at least 10 days prior to submitting the amendment to the federal government for approval. The statute requires DHHS to notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division when an amendment is posted to DHHS's website. Current law does not require DHHS to provide notice to the General Assembly when a State Plan amendment has been submitted for federal approval.

BILL ANALYSIS: **Section 12** of the PCS adds requirements for DHHS to give notice to the Joint Legislative Oversight Committee and Medicaid and NC Health Choice and the Fiscal Research Division regarding the submission of State Plan amendments that are posted to DHHS's website in accordance with G.S. 108A-54.1A(d). The PCS requires DHHS to give notice when a State Plan amendment is submitted for federal approval and to give notice when DHHS decides not to submit a proposed State Plan amendment that was posted. The PCS also requires DHHS to give notice upon submission of a modification to a previously-submitted State Plan amendment.

EFFECTIVE DATE: **Part III** of the PCS is effective when it becomes law and applies to State Plan amendments posted on DHHS's website on or after that date.

PART IV. CONFORMING CHANGES TO LME/MCO APPEALS

CURRENT LAW: Chapter 108D of the General Statutes governs the process for Medicaid beneficiaries who are enrolled with an LME/MCO to appeal decisions made by LME/MCOs and to file grievances with LME/MCOs. Medicaid beneficiaries enroll with an LME/MCO in order to receive behavioral health services. The statutes in Chapter 108D allow enrollees to appeal certain LME/MCO actions through an LME/MCO level (first-level) appeal and to appeal the LME/MCO's resolution of the first-level appeal by requesting a contested case hearing with the Office of Administrative Hearings. The statutes also allow enrollees to file grievances with LME/MCOs related to matters that are not subject to appeal.

The State is required to establish procedures for Medicaid enrollee appeals and grievances in accordance with federal managed care regulations in Part 438 of Title 42 of the Code of Federal Regulations. Effective July 5, 2016, changes were made to these federal regulations that conflict with certain provisions in Chapter 108D.

BILL ANALYSIS: **Section 14** of the PCS amends the definitions pertaining to LME/MCO grievances and appeals by replacing the term "managed care action" with the term "adverse benefit determination" in accordance with a change to that terminology in the federal regulations. Conforming changes are made in **Section 15** of the PCS and throughout the **Part IV** of the PCS.

Section 16 of the PCS amends the statute governing standard LME/MCO level enrollee appeals to do the following:

- Allows enrollees 60 days instead of 30 days to request an LME/MCO level appeal after receiving a notice of adverse benefit determination.
- Requires LME/MCOs to resolve an LME/MCO level appeal and send a notice of resolution to the enrollee within 30 days instead of 45 days after receiving the request for appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 17 of the PCS amends the statute governing expedited LME/MCO level appeals to do the following:

- Requires LME/MCOs to resolve expedited LME/MCO level appeals within 72 hours instead of three working days after receiving the request for expedited appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 18 of the PCS amends the statute governing enrollee contested case hearings to allow enrollees 120 days instead of 30 days after the mailing date of the notice of resolution to file a request for an appeal at the Office of Administrative Hearings.

EFFECTIVE DATE: **Part IV** of the PCS is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

PART V. EFFECTIVE DATE

EFFECTIVE DATE: **Section 3** of the PCS would become effective January 1, 2018. The remainder of the PCS would become effective when the bill becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H 2

HOUSE BILL 403
Committee Substitute Favorable 3/29/17

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

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT MODIFYING CERTAIN REQUIREMENTS PERTAINING TO LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (DHHS) shall specify a single, nationally recognized, standardized electronic format to be used by all local management entities/managed care organizations (LME/MCOs) when submitting encounter data to DHHS. LME/MCOs must submit to 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 utilizing the single, nationally recognized, standardized electronic format specified by DHHS.

SECTION 1.(b) DHHS may use encounter data submitted by LME/MCOs for all of the following purposes:

(1) Setting LME/MCO capitation rates.
(2) Measuring the quality of services managed by LME/MCOs.
(3) Assuring compliance with State and federal regulations.
(4) Conducting oversight and audit functions.
(5) Other purposes determined necessary by DHHS.

SECTION 1.(c) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

SECTION 1.(d) DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services regarding the status of subsection (a) of this section on or before February 1, 2018.

SECTION 2.(a) G.S. 122C-112.1(a)(39) reads as rewritten:

"(39) Develop and use ~~a~~ standard ~~contract~~ contracts for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver and management of State appropriations and federal block grant funds that requires compliance by each LME/MCO with all provisions of the ~~contract~~ contracts to operate the 1915(b)/(c) Medicaid Waiver and manage State appropriations and federal block grant funds and with all applicable provisions of State and federal law. Each of these standard contracts must include quality outcome measures for mental health, developmental disabilities, and substance use disorders."

SECTION 2.(b) This section applies to contracts entered into on or after the effective date of this act.

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

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

(1) "Area authority" means the area mental health, developmental disabilities, and substance abuse authority.

(2) "Area board" means the area mental health, developmental disabilities, and substance abuse ~~board.~~board that is the governing body for the area authority, local management entity, or local management entity/managed care organization.

(2a) "Area director" means the administrative head of the area ~~authority program~~ authority, local management entity, or local management entity/managed care organization appointed pursuant to G.S. 122C-121. All provisions of Chapter 122C of the General Statutes that apply to the area director also apply to the administrative head of the area authority, LME, or LME/MCO, regardless of whether (i) the administrative head uses the title "CEO" or any other name or title assigned to him or her by the area authority, LME, or LME/MCO and (ii) a contract, memorandum of understanding, or other agreement in effect between the Department and the area authority, LME, or LME/MCO refers to the administrative head as the "CEO" or any other name or title.

(2b) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area ~~authorities and multicounty programs.~~authorities.

...

(5) "Catchment area" means the geographic part of the State served by a specific area ~~authority or county program.~~authority.

...

~~(10a) "County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.~~

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority or county program.~~authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area ~~authority or county program.~~authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;
d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;
e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;
f. A "State facility", which is a facility that is operated by the Secretary;
g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and
h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.

...

(20b) "Local management entity" or "LME" means an area ~~authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.~~authority.

...

~~(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.~~

...."

SECTION 4.(a) G.S. 122C-115.4(b) reads as rewritten:

"(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME obtains the prior written approval of the Secretary to voluntarily ~~enters~~ enter into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services and administrative functions described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.
(2) Provider monitoring, technical assistance, capacity development, and quality control. If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.
(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.
b. Addressing difficult situations for clients or providers.
c. Consulting with providers regarding difficult or unusual care situations.
d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.
e. Coordinating client transitions from one service to another.
f. Conducting customer service interventions.
g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(8) Each LME shall develop a waiting list of persons with intellectual or developmental disabilities that are waiting for specific services. The LME shall develop the list in accordance with rules adopted by the Secretary to ensure that waiting list data are collected consistently across LMEs. Each LME shall report this data annually to the Department. The data collected should include numbers of persons who are:

a. Waiting for residential services.
b. Potentially eligible for CAP-MRDD.
c. In need of other services and supports funded from State appropriations to or allocations from the Division of Mental Health,

Developmental Disabilities, and Substance Abuse Services, including CAP-MRDD.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions."

SECTION 4.(b) This section applies to contracts entered into on or after the effective date of this act.

SECTION 5. G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area ~~authority; status of consolidated human services agency.~~authority.**

~~(a)~~ An area authority is a local political subdivision of the ~~State.~~State established by counties pursuant to G.S. 122C-115(a) and (c) for the management and delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance use disorders under a 1915(b)/(c) Medicaid Waiver. An area authority is a local management entity that must perform the local management entity functions described in G.S. 122C-115.4 and monitor and manage all public resources that may be available for mental health, intellectual and developmental disabilities, and substance use disorder services, including federal block grants, federal funding for Medicaid and NC Health Choice, and all other public funding sources as described in Section 1(a) of S.L. 2011-264 and in compliance with G.S. 122C-111 and G.S. 122C-112.1(a)(39). LMEs are the single entities authorized to operate and manage the 1915(b)/(c) Medicaid Waiver, which operation and management must be performed in accordance with a standard contract developed by the Secretary under the authority of G.S. 122C-112.1(a)(39) that is subject to the enforcement provisions of G.S. 122C-124.1, G.S. 122C-124.2, and all other applicable provisions of this Chapter. LMEs are the sole entities authorized to enter into the contract described in G.S. 122C-124.2(g)(2) and G.S. 122C-112.1(a)(39) for the operation of the 1915(b)/(c) Medicaid Waiver. A local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under section 1915(b) and section 1915(c) of the Social Security Act shall be known as a "local management entity/managed care organization" or "LME/MCO."

~~(b) A consolidated human services agency is a department of the county.~~"

SECTION 6.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

…

(7) Appoint an area director in accordance with ~~G.S. 122C-121(d).~~G.S. 122C-121.

…

(18) Maintain disability-specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(19) Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

(20) Maintain full accountability for all aspects of Medicaid Waiver operations and for meeting all contract requirements specified by the Department.

…

(a2) An area authority may, but shall not be required to, subcontract to other entities, upon the prior written approval of the Secretary, only the following managed care functions:

(1) Information systems.

(2) Customer service (including call center) operations.

(3) Claims processing.
(4) Provider, enrollment, credentialing, and monitoring.
(5) Professional services.
(6) Treatment Plan development.
(7) Referral to services.

An area authority shall not subcontract to other entities any other managed care functions or nonservice activities.

...."

SECTION 6.(b) G.S. 122C-117(a2), as enacted by subsection (a) of this section, applies to area authority subcontracts to other entities entered into on or after the date this act becomes law.

SECTION 7.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) An area board shall have no fewer than 11 and no more than 21 voting members. ~~The~~

(a1) Unless the Secretary approves an alternative board appointment process pursuant to subsection (a2) of this section, the board of county commissioners, or the boards of county commissioners within the area, shall appoint members in a manner that ensures participation from each of the constituent counties of the area authority and is consistent with the requirements provided in subsection (b) of this section. ~~The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category.~~ If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint members of the unrepresented categories.

(a2) The boards of county commissioners within a multicounty area with a catchment population of at least 1,250,000 shall have the option to appoint members of the area board ~~in a manner or with a composition~~ through a process other than as required by subsection (a1) of this section ~~by~~ if at least three-quarters of the constituent counties each ~~county adopting~~ adopt a resolution to that effect and ~~receiving~~ obtain written approval from the Secretary. When seeking written approval from the Secretary to use an alternative board appointment process, the area authority shall submit to the Secretary its proposed board appointment process and copies of county resolutions requesting approval of the proposed board appointment process. In cases in which two or more area authorities seek to merge or consolidate, if one or more of these area authorities received approval by the Secretary for an alternative board appointment process prior to the merger or consolidation, all prior approvals for an alternative board appointment process become void 30 days after the effective date of the merger or consolidation. The newly merged or consolidated area authority and the boards of county commissioners within the multicounty area may appoint members of the area board through a process other than as provided in subsection (a1) of this section if at least three-quarters of the constituent counties each adopt a resolution to that effect and obtain written approval from the Secretary in the manner prescribed by this subsection. No area board shall be exempt from, and the Secretary shall not waive, any provision of this section except as provided in subsection (a1) of this section with respect to the board appointment process.

(a3) A member of the board may be removed with or without cause by the ~~initial~~ appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chair of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the ~~initial~~ appointing authority before the end of the term of the vacated seat or within 90 days ~~of~~ after the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) Within the maximum membership provided in subsection (a) of this section, the membership of the area board shall reside within the catchment area and be composed as follows:

(1) At least one member who is a current county commissioner.

(2) The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
a. Individuals with mental illness.
b. Individuals in recovery from addiction.
c. Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:
a. Individuals with mental illness.
b. Individuals with intellectual or other developmental disabilities.
c. Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with ~~insurance expertise consistent with the scale and nature of the managed care organization.~~health insurance, health plan administration, or business expertise, or any combination of expertise in these areas.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

(13) An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

Except as provided in subdivisions (12) and (13) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area ~~authority~~ board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

...

(d1) Beginning on July 1, 2017, each LME/MCO annually shall notify the Secretary of all of the following:

(1) The area board appointment process, the process for filling vacancies on the area board, and the appointing authority for each area board position.

(2) The membership of the area board.

(3) The county of residence of each member.

(4) How the membership composition requirements of subsection (b) of this section are being met.

(5) The term of office of the chair of the area board and each member.

(6) The LME/MCO's compliance status with training requirements for its board members.

(7) The board's policies and procedures for conducting the area director's annual performance review, including at least all of the following:

a. The criteria used to conduct the review.

b. The criteria used to award bonuses to the area director and other employees.

c. The process for soliciting comments from county commissioners.

d. The results of the area director's most recent performance evaluation.

...."

SECTION 7.(b) Any area board that does not meet the composition requirements of G.S. 122C-118.1(b) on the effective date of this act shall comply with these composition requirements no later than October 1, 2017.

SECTION 8.(a) Part 4 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-147.3. LME/MCO use of funds.**

LME/MCOs shall use funds only for purposes related to their functions and responsibilities under this Chapter, including operation of the combined Medicaid Waiver program authorized under section 1915(b) and 1915(c) of the Social Security Act, or to carry out functions and responsibilities required by State law, federal law, or contract with the Department of Health and Human Services. A violation of this section constitutes noncompliance for purposes of G.S. 122C-124.2(c)."

SECTION 8.(b) G.S. 122C-124.2(c) reads as rewritten:

"(c) If the Secretary (i) does not provide a local management entity/managed care organization with the certification of compliance required by this section based upon the LME/MCO's failure to comply with any of the requirements specified in subdivisions (1) through (3) of subsection (b) of this ~~section,~~ section or (ii) determines that an LME/MCO has failed to comply with G.S. 122C-147.3, the Secretary shall do the following:

(1) Prepare a written notice informing the LME/MCO of the provisions of subdivision (1), (2), or (3) of subsection (c) of this section or the provisions of G.S. 122C-147.3 with which the LME/MCO is deemed not to be in compliance and the reasons for the determination of noncompliance.

(2) Cause the notice of the noncompliance to be delivered to the LME/MCO.

(3) Not later than 10 days after the Secretary's notice of noncompliance is provided to the LME/MCO, assign the Contract of the noncompliant LME/MCO to a compliant LME/MCO.

(4) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to the compliant LME/MCO in accordance with the provisions in subsection (e) of this section."

SECTION 9.(a) G.S. 122C-121 reads as rewritten:

"**§ 122C-121. Area director.**

(a) The area director is ~~an~~ a full-time employee of the area board, shall serve full time at the pleasure of the area board, and shall be appointed by the area board in accordance with G.S. 122C-117(7). The area director shall not be employed in any other capacity or enter into any other contract for the performance of services while serving as area director. As used in this subsection, "employee" means an individual and does not include a corporation, a partnership, a limited liability corporation, or any other business association.

(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Human Resources ~~Commission. Any salary that is higher than the maximum of the applicable salary range shall be~~ Commission so long as all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within ~~the~~ a comparable region of North Carolina and shall also include the specific amount the board proposes to pay the director. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary from both the Director of the Office of State Human Resources and the Secretary. In no instance shall the area board, the Director of the Office of State Human Resources, or the Secretary approve a salary for an area director that is higher than the maximum of the applicable salary range if it exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, as determined by the Secretary. If the Secretary determines that an area director's salary is higher than the maximum of the applicable salary range and exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, that area director's salary shall be reduced to achieve compliance with this subdivision within 60 days after such determination by the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(a2) The area board shall not authorize any salary adjustment for an area director that ~~is~~ results in a salary above the normal allowable salary ~~range without obtaining prior approval from the Director of the Office of State Human Resources.~~range, or pay any salary above the normal allowable salary range, unless all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within a comparable region of North Carolina and shall also include the specific amount of the salary adjustment the board proposes to pay the area director and the resulting salary. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary adjustment from both the Director of the Office of State Human Resources and the Secretary. In no instance shall the area board, the Director of the Office of State Human Resources, or the Secretary approve a salary adjustment for an area director that results in a salary that is higher than the maximum of the applicable salary range if it exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, as determined by the Secretary. If the Secretary determines that an area director's salary is higher than the maximum of the applicable salary range and exceeds by more than thirty percent (30%) the average salary of the area directors of the remaining LME/MCOs, that area director's salary shall be reduced to achieve compliance with this subdivision within 60 days after such determination by the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(a3) If the Secretary determines that the compensation of an area director, including salary, benefits, and bonuses, exceeds the limitations specified in this section, the area board shall prospectively reduce that area director's compensation, including salary, benefits, and bonuses, to achieve compliance with this section and notify the Secretary within 60 days after such determination by the Secretary. If an area board does not bring an area director's compensation, including salary, benefits, and bonuses, into compliance with this section within the 60-day period, the Secretary shall notify, in writing, the area board and the applicable participating boards of county commissioners of the area authority specifically how the Secretary determined that the area director's compensation, including salary, benefits, and bonuses, does not comply with this section, and that the area board must bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section or a caretaker board of directors will be appointed as provided in G.S. 122C-124.1(c). The area board shall have 60 days from the date it receives notice under this subsection to bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section.

If, at the end of the 60-day notice period, the area board has not brought the area director's compensation, including salary, benefits, and bonuses, into compliance with this section, the Secretary shall appoint a caretaker board of directors as provided in G.S. 122C-124.1(c). The Secretary may assign any or all of the powers and duties of the area director or of the area board to the caretaker board as the Secretary deems necessary and appropriate. In addition to performing all of these powers and duties, the caretaker board shall bring the area director's compensation, including salary, benefits, and bonuses, into compliance with this section. The Secretary may terminate the area director's employment when it appoints a caretaker board. Neither party to any applicable employment contract shall be entitled to damages. After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area authority.

~~(a2)~~(a4) The area board shall not provide the area director with any benefits or bonuses that are not also provided by the area board to all permanent employees of the area program, except that the area board may, in its discretion, offer severance benefits, relocation expenses, or both, to an applicant for the position of area director as an incentive for the applicant to accept an offer of employment. The area director shall be reimbursed only for allowable

employment-related expenses at the same rate and in the same manner as other employees of the area program.

(a5) The total compensation provided or recommended to be provided by each area board to its area director, including salary, benefits, and bonuses, shall be reviewed for written approval by the Director of the Office of State Human Resources and the Secretary on at least an annual basis to determine compliance with the requirements of this section. An area board shall not increase compensation to an area director without prior written approval for the increase from the Director of the Office of State Human Resources and the Secretary.

(a6) Annually on June 30, each area board shall submit to the Secretary and the Director of the Office of State Human Resources a copy of all current employment agreements, employment contracts, and any amendments to those agreements and contracts that the area board has entered into with its area director, as well as any other documents relating to the area director's compensation, including salary, benefits, and bonuses.

(b) The Secretary and the area board shall evaluate annually the area director for performance based on criteria established by the Secretary and the area board. In conducting the evaluation, the Secretary and the area board shall consider comments from the board of county commissioners.

(c) The area director is the administrative head of the area program. In addition to the duties under G.S. 122C-111, the area director shall:

(1) Appoint, supervise, and terminate area program staff.
(2) Administer area authority services.
(3) Develop the budget of the area authority for review by the area board.
(4) Provide information and advice to the board of county commissioners through the county manager.
(5) Act as liaison between the area authority and the Department.
(6) Ensure compliance by the area authority with the powers and duties of the area authority established under G.S. 122C-117.

(d) Except when specifically waived by the Secretary, the area director shall meet all the following minimum qualifications:

(1) Masters degree.
(2) Related experience.
(3) Management experience.
(4) Any other qualifications required under G.S. 122C-120.1.

(e) The appointment of the area director shall be based upon the recommendation of at least two candidates by a search committee of the area board. The search committee shall include a consumer board member, a county commissioner, and an appointee of the Secretary. The Secretary may waive this requirement when appointment of the area director results from the merger or consolidation of LME/MCOs.

(f) The area board may not terminate the employment of an area director without 30 days' prior written notice to the Secretary, unless the termination (i) results from the merger or consolidation of LME/MCOs or (ii) is directed by the Secretary."

SECTION 9.(b) The limitations on compensation, including salary, benefits, and bonuses specified in G.S. 122C-121, as amended by subsection (a) of this section, apply to currently employed area directors hired prior to the effective date of this act as well as to area directors hired on or after the effective date of this act. If the Secretary of the Department of Health and Human Services determines that the compensation, including salary, benefits, and bonuses, of a currently employed area director hired prior to the effective date of this act exceeds the limitations specified in G.S. 122C-121, as amended by subsection (a) of this section, the area board shall prospectively reduce that area director's compensation, including salary, benefits, and bonuses, to achieve compliance with G.S. 122C-121, as amended by subsection (a) of this section, within 60 days after such determination by the Secretary. If an

area board does not comply with the directive of this subsection to reduce an area director's compensation, including salary, benefits, and bonuses, to achieve compliance with G.S. 122C-121, as amended by subsection (a) of this section, within the 60-day period prescribed by this subsection, the Secretary shall appoint a caretaker board of directors, as prescribed in G.S. 122C-121(a3), as amended by subsection (a) of this section.

SECTION 9.(c) Each LME/MCO shall, within 30 day after the effective date of this act, submit to the Secretary and the Director of the Office of State Human Resources a copy of all current employment agreements, employment contracts, and any amendments to those agreements and contracts that the LME/MCO has entered into with its area director, as well as any other documents relating to the area director's compensation, including salary, benefits, and bonuses.

SECTION 10. G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

(a) Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. ~~Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1.~~

(b) Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Human Resources ~~Commission. Any salary that is higher than the maximum of the applicable salary range shall~~ Commission so long as all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within ~~the~~ a comparable region of North Carolina and shall also include the specific amount the board proposes to pay the employee. For the purpose of this subdivision, the Secretary shall determine what constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary from both the Director of the Office of State Human Resources and the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes.

(c) The area board shall not authorize any salary adjustment that ~~is~~ results in a salary above the normal allowable salary range ~~without obtaining prior approval the Director of the Office of State Human Resources.~~ unless all of the following requirements are met:

(1) The area board must submit to the Director of the Office of State Human Resources and the Secretary a request to exceed the maximum of the applicable salary range. The request must be supported by documentation of comparable salaries in comparable operations within a comparable region of North Carolina and shall also include the specific amount of the salary adjustment the board proposes to pay the employee and the resulting salary. For the purpose of this subdivision, the Secretary shall determine what

constitutes comparable operations within a comparable region of North Carolina.

(2) The area board must obtain prior written approval for the proposed salary adjustment from both the Director of the Office of State Human Resources and the Secretary.

The requirements of subdivisions (1) and (2) of this subsection may not be waived by the area board, the Director of the Office of State Human Resources, or the Secretary regardless of whether the State Human Resources Commission has made a determination under G.S. 126-11 that all or a portion of the board's personnel system has been determined to be substantially equivalent to, and therefore exempt from, the provisions of Chapter 126 of the General Statutes."

SECTION 11. G.S. 126-11 reads as rewritten:

"**§ 126-11. Local personnel system may be established; approval and monitoring; rules and regulations.**

(a) The board of county commissioners of any county may establish and maintain a personnel system for all employees of the county subject to its jurisdiction, which system and any substantial changes to the system, shall be approved by the State Human Resources Commission as substantially equivalent to the standards established under this Chapter for employees of local departments of social services, local health departments, ~~and~~ area mental health programs, and local emergency management programs. If approved by the State Human Resources Commission, the employees covered by the county system shall be exempt from all provisions of this Chapter except Article 6.

(a1) With approval of each of the boards of commissioners of the county or counties which comprise the area mental health authority, the area mental health authority may establish and maintain a personnel system for all employees of the area mental health authority, which system and any substantial changes to the system, shall be equivalent to the standards established under this Chapter for employees of area mental health authorities. If approved by the State Human Resources Commission, the employees covered by the area mental health authority system shall be exempt from all provisions of this Chapter except Article 6.

(b) A board of county commissioners may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements ~~in (a) above.~~ of subsection (a) of this section. Upon such determination, county employees shall be exempt from the provisions of this Chapter relating to the approved portions of the county personnel system.

(b1) The board of an area mental health authority, with the approval of each of the boards of commissioners of the county or counties which comprise the area mental health authority, may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements ~~in subsection (a1) above.~~ of subsection (a1) of this section. Upon such determination, area mental health authority employees shall be exempt from the provisions of this Chapter relating to the approved portions of the area mental health authority personnel system except as provided in G.S. 122C-121.

(b2) Upon the merger or consolidation of two or more local management entities/managed care organizations, any determination made prior to the effective date of that merger or consolidation that all or a portion of any applicable area mental health authority personnel system is substantially equivalent is void. The board of the newly merged or consolidated area mental health authority, with the approval of the boards of commissioners of three-quarters of the counties which comprise the newly merged or consolidated area mental health authority, may petition the State Human Resources Commission to determine whether any portion of its total personnel system meets the requirements of subsection (a1) of this section. Upon such determination, area mental health authority employees shall be exempt from

the provisions of this Chapter relating to the approved portions of the area mental health authority personnel system except as provided in G.S. 122C-121 and G.S. 122C-154.

(c) The Office of State Human Resources shall monitor at least annually county or area mental health authority personnel systems approved under this section in order to ensure compliance.

(d) In order to define "substantially equivalent," the State Human Resources Commission is authorized to promulgate rules and regulations to implement the federal merit system standards and these regulations at a minimum shall include: recruitment and selection of employees; position classification; pay administration; training; employee relations; equal employment opportunity; and records and reports."

SECTION 12. Section 12F.2(a) of S.L. 2015-241 reads as rewritten:

"**SECTION 12F.2.(a)** For the purpose of mitigating cash flow problems that many LME/MCOs experience at the beginning of each fiscal year relative to single stream funding, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), shall distribute not less than one-twelfth of each LME/MCO's ~~continuation~~ base budget allocation at the beginning of the fiscal year and subtract the amount of that distribution from the LME/MCO's total reimbursements for the fiscal year. For each month of the fiscal year after July, the DMH/DD/SAS shall distribute, on the first Tuesday of the month, one-eleventh of the amount of each LME/MCO's single-stream allocation that remains after subtracting the amount of the distribution that was made to the LME/MCO in July of the fiscal year."

SECTION 13. G.S. 122C-141(d)(1) reads as rewritten:

"(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Commission. ~~A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.~~"

SECTION 14. G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the General Statutes are repealed.

SECTION 15. The Revisor of Statutes shall delete every reference to G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human services agency" wherever they occur in Chapter 122C of the General Statutes.

SECTION 16. Section 12 of this act becomes effective July 1, 2017. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 403
Committee Substitute Favorable 3/29/17
PROPOSED SENATE COMMITTEE SUBSTITUTE H403-CSTR-6 [v.12]
06/13/2017 5:58:12 PM

Short Title: Behavioral Health and Medicaid Modifications. (Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO MODIFY CERTAIN REQUIREMENTS PERTAINING TO LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS, TO MODIFY THE MEDICAID TRANSFORMATION LEGISLATION, TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO NOTIFY THE GENERAL ASSEMBLY UPON THE SUBMISSION OR NON-SUBMISSION OF A MEDICAID STATE PLAN AMENDMENT, AND TO MAKE CHANGES TO THE NORTH CAROLINA LME/MCO ENROLLEE GRIEVANCES AND APPEALS STATUTES TO CONFORM WITH RECENT CHANGES TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

PART I. LME/MCO MODIFICATIONS

SECTION 1. On the date when Medicaid capitated contracts with Prepaid Health Plans (PHPs) begin, as required by S.L. 2015-245, all of the following shall occur:

(1) PHPs shall manage all publicly-funded behavioral health services currently managed by the local management entities/managed care organizations (LME/MCOs) under contracts with the Department of Health and Human Services (DHHS).

(2) The LME/MCOs shall be dissolved.

(3) All remaining assets of the LME/MCOs, including all funds in the Medicaid risk reserve account shall be transferred to DHHS to be used to satisfy the liabilities of the LME/MCOs and for costs of the contracts with PHPs for the management of publicly-funded behavioral health services. In the event there are insufficient assets to satisfy the liabilities of the LME/MCOs, it shall be the responsibility of the Secretary to satisfy the liabilities of the LME/MCOs or arrange for the transfer of those liabilities to PHPs.

SECTION 2.(a) The Department of Health and Human Services (DHHS) shall specify a single, nationally recognized, standardized electronic format to be used by all local management entities/managed care organizations (LME/MCOs) when submitting encounter data to DHHS. LME/MCOs must submit to 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 utilizing the single, nationally recognized, standardized electronic format specified by DHHS.

SECTION 2.(b) DHHS may use encounter data submitted by LME/MCOs for all of the following purposes:

(1) Setting LME/MCO capitation rates.
(2) Measuring the quality of services managed by LME/MCOs.
(3) Assuring compliance with State and federal regulations.
(4) Conducting oversight and audit functions.
(5) Other purposes determined necessary by DHHS.

SECTION 2.(c) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

SECTION 2.(d) DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services regarding the status of subsection (a) of this section on or before February 1, 2018.

SECTION 3.(a) G.S. 122C-112.1(a)(39) reads as rewritten:

"(39) Develop and use ~~a~~ standard ~~contract~~ contracts for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid Waiver and management of State appropriations and federal block grant funds that requires compliance by each LME/MCO with all provisions of the ~~contract~~ contracts to operate the 1915(b)/(c) Medicaid Waiver and manage State appropriations and federal block grant funds and with all applicable provisions of State and federal law. Each of these standard contracts must include quality outcome measures for mental health, developmental disabilities, and substance use disorders."

SECTION 3.(b) This section is effective January 1, 2018 and applies to contracts entered into on or after that date.

SECTION 4. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

(1) "Area authority" means the area mental health, developmental disabilities, and substance abuse authority.
(2) "Area board" means the area mental health, developmental disabilities, and substance abuse ~~board.~~board that is the governing body for the area authority, local management entity, or local management entity/managed care organization.
(2a) "Area director" means the administrative head of the area ~~authority program~~ authority, local management entity, or local management entity/managed care organization appointed pursuant to G.S. 122C-121. All provisions of Chapter 122C of the General Statutes that apply to the area director also apply to the administrative head of the area authority, LME, or LME/MCO, regardless of whether (i) the administrative head uses the title "CEO" or any other name or title assigned to him or her by the area authority, LME, or LME/MCO and (ii) a contract, memorandum of understanding, or other agreement in effect between the Department and the area authority, LME, or LME/MCO refers to the administrative head as the "CEO" or any other name or title.
(2b) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area ~~authorities and multicounty programs.~~authorities.
...
(5) "Catchment area" means the geographic part of the State served by a specific area ~~authority or county program.~~ authority.
...

~~(10a) "County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.~~

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority or county program.~~authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area ~~authority or county program.~~authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

...

...

(20b) "Local management entity" or "LME" means an area ~~authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.~~authority.

...

~~(29a) "Program director" means the director of a county program established pursuant to G.S. 122C-115.1.~~

...."

SECTION 5. G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with ~~G.S. 122C-121(d).~~G.S. 122C-121.

...

(18) Maintain disability-specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(19) Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

(20) Maintain full accountability for all aspects of Medicaid Waiver operations and for meeting all contract requirements specified by the Department."

SECTION 6. G.S. 122C-124.1 reads as rewritten:

"**§ 122C-124.1. Actions by the Secretary upon area authority or area director failure to comply or when area authority ~~or county program~~ is not providing minimally adequate services.**

(a) Notice of Likelihood of Action. – When the Secretary determines that there is a likelihood of suspension of funding, assumption of service delivery or management functions, or appointment of a caretaker board under this section within the ensuing 60 days, the Secretary shall so notify in writing the area authority board ~~or the county program~~ and the board of county commissioners of the area ~~authority or county program.~~authority. The notice shall state the particular deficiencies in program services or administration that must be remedied to avoid

action by the Secretary under this section. The area authority board ~~or county program~~ shall have 60 days from the date it receives notice under this subsection to take remedial action to correct the deficiencies. The Secretary shall provide technical assistance to the area authority ~~or county program~~ in remedying deficiencies.

(b) Suspension of Funding; Assumption of Service Delivery or Management Functions. – If the Secretary determines that ~~a county, through~~ (i) an area authority or ~~county program,~~ area director has failed to comply with any requirement of State or federal law, rule, or regulation, or any requirement of the area authority's contract with the Department; or (ii) an area authority is not providing minimally adequate services to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, then the Secretary, after providing written notification of the Secretary's intent to the area authority ~~or county program~~ and to the board of county commissioners of the area ~~authority or county program,~~ authority, and after providing the area authority ~~or county program~~ and the boards of county commissioners of the area authority ~~or county program~~ an opportunity to be heard, may:

(1) Withhold funding for the particular service or services in question from the area authority ~~or county program~~ and ensure the provision of these services through contracts with public or private agencies or by direct operation by the Department.

Upon suspension of funding, the Department shall direct the development and oversee implementation of a corrective plan of action and provide notification to the area authority ~~or county program~~ and the board of county commissioners of the area authority ~~or county program~~ of any ongoing concerns or problems with the area authority's ~~or county program's~~ finances or delivery of services.

(2) Assume control of the particular service or management functions in question or of the area authority ~~or county program~~ and appoint an administrator to exercise the powers assumed. This assumption of control shall have the effect of divesting the area authority ~~or county program~~ of its powers in G.S. 122C-115.1 and G.S. 122C-117 and all other service delivery powers conferred on the area authority ~~or county program~~ by law as they pertain to this service or management function. County funding of the area authority ~~or county program~~ shall continue when the State has assumed control of the catchment area or of the area ~~authority or county program.~~authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area ~~authority or county program.~~authority.

Upon assumption of control of service delivery or management functions, the Department shall, in conjunction with the area ~~authority or county program,~~ authority, develop and implement a corrective plan of action and provide notification to the area authority ~~or county program~~ and the board of county commissioners of the area authority ~~or county program~~ of the plan. The Department shall also keep the area authority board and the board of county commissioners informed of any ongoing concerns or problems with the delivery of services.

(c) Appointment of Caretaker Administrator. – In the event that a county, through an area ~~authority or county program,~~ authority, fails to comply with the corrective plan of action required when funding is suspended or when the State assumes control of service delivery or management functions, the Secretary, after providing written notification of the Secretary's intent to the area authority ~~or county program~~ and the applicable participating boards of county commissioners of the area ~~authority or county program,~~ authority, shall appoint a caretaker administrator, a caretaker board of directors, or both.

The Secretary may assign any of the powers and duties of the area director or program director or of the area authority board or board of county commissioners of the area authority ~~or county program~~ pertaining to the operation of mental health, developmental disabilities, and substance abuse services to the caretaker board or to the caretaker administrator as it deems necessary and appropriate to continue to provide direct services to clients, including the powers as to the adoption of budgets, expenditures of money, and all other financial powers conferred on the area authority ~~or county program~~ by law pertaining to the operation of mental health, developmental disabilities, and substance abuse services. County funding of the area authority ~~or county program~~ shall continue when the State has assumed control of the financial affairs of the program. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area ~~authority or county program.~~ authority. The caretaker administrator and the caretaker board shall perform all of these powers and duties. The Secretary may terminate the area director ~~or program director~~ when it appoints a caretaker administrator. Chapter 150B of the General Statutes shall apply to the decision to terminate the area ~~director or program~~ director. Neither party to any such contract shall be entitled to damages. After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area ~~authority or county program.~~authority."

SECTION 7. G.S. 122C-151 reads as rewritten:

"**§ 122C-151. Responsibilities of those receiving appropriations.**

(a) All resources allocated to and received by any area authority and used for programs of mental health, developmental disabilities, substance abuse or other related services are subject to the conditions specified in this Article and to the rules of the Commission and the Secretary and to the conditions of the ~~Memorandum of Agreement specified in G.S. 122C-143.2.~~ memorandum of agreement with the Secretary specified in G.S. 122C-115.2(d). Area authorities shall not use any resources for any of the following expenses:

(1) Alcohol.
(2) First-class airfare.
(3) Charter flights.
(4) Holiday parties or similar social gatherings.
(5) Any meeting, whether a formal public meeting or an informal retreat, of the area board outside of the State.

(b) If an area authority fails to complete actions necessary for ~~the development of a Memorandum of Agreement~~ the memorandum of agreement, fails to file required reports within the time limit set by the Secretary, or fails to comply with any other requirements specified in this Article, the Secretary may:

(1) Delay payments; and
(2) With written notification of cause and subject to an appeal as provided by G.S. 122C-151.2, reduce or deny payment of funds. Restoration of funds upon compliance is within the discretion of the Secretary."

SECTION 8.(a) The definitions in G.S. 122C-3 apply to this section.

SECTION 8.(b) The Office of State Human Resources and the State Human Resources Commission shall revise and update the job description and salary range for area directors as follows:

(1) No later than September 1, 2017, the Office of State Human Resources, in collaboration with the Secretary of the Department of Health and Human Services and the LME/MCO area boards, shall revise and update the job description for area directors, taking into account the LME/MCOs' functions and current size, including number of covered lives, annual service and administrative expenditures, and geographic service areas.

(2) No later than December 1, 2017, the Office of State Human Resources shall recommend to the State Human Resources Commission a revision to the salary range for area directors. In forming its recommendation, the Office of State Human Resources shall conduct a market compensation study of organizations nationwide with similar functions as the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographic service areas. The market compensation study shall include both public and not-for-profit managed care organizations. In forming its recommendation, the Office of State Human Resources shall seek input from the Secretary of the Department of Health and Human Services and the LME/MCO area boards.

(3) No later than March 1, 2018, the State Human Resources Commission shall revise the salary range for area directors based on the recommendation of the Office of State Human Resources. Once a new salary range for area directors is adopted, the State Human Resources Commission shall inform each LME/MCO's area board of the new salary range.

SECTION 8.(c) The salary range for area directors, which was last updated by the State Human Resources Commission in 2010, is void. Beginning on the date this act becomes law, the LME/MCO area boards shall not authorize any increase in the salaries of an area director until the Office of State Human Resources and the State Human Resources Commission complete a revision and update of the job description and salary range of the area directors as required by subsection (b) of this section. This section shall not be construed to prohibit an LME/MCO from authorizing a salary pursuant to G.S. 122C-121(a1) to be paid to an area director filling a vacant position after the date this act becomes law.

SECTION 8.(d) After completion of the revision and update required by subsection (b) of this section, each LME/MCO area board shall reestablish the salary for its area director in accordance with G.S. 122C-121(a1). This subsection applies to contracts with area directors beginning on or after the date that the State Human Resources Commission revises the salary range for area directors as required by subdivision (3) of subsection (b) of this section.

SECTION 8.(e) After the date that the State Human Resources Commission revises the salary range for area directors as required by subdivision (3) of subsection (b) of this section and until the LME/MCOs are dissolved pursuant to Section 1 of this act, the Office of State Human Resources, at the discretion of the Director of the Office of State Human Resources, may recommend to the State Human Resources Commission adjustments to the salary range for area directors. In forming a recommendation under this subsection, the Office of State Human Resources shall conduct a market compensation study of organizations nationwide with similar functions as the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographic service areas. The market compensation study shall include both public and not-for-profit managed care organizations. In forming a recommendation under this subsection, the Office of State Human Resources shall seek input from the Secretary of the Department of Health and Human Services and the LME/MCO area boards.

SECTION 9.(a) G.S. 122C-141(d)(1) reads as rewritten:

"(1) The public provider must meet all the provider qualifications as defined by rules adopted by the Commission. ~~A county that satisfies its duties under G.S. 122C-115(a) through a consolidated human services agency may not be considered a qualified provider for purposes of this subdivision.~~"

SECTION 9(b). G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the General Statutes are repealed.

SECTION 9(c). The Revisor of Statutes shall delete every reference to G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human services agency" wherever they occur in Chapter 122C of the General Statutes.

PART II. MEDICAID TRANSFORMATION MODIFICATIONS

SECTION 10. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, 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 shall be responsible for planning and implementing the Medicaid transformation required by this act. DHHS shall have the authority to adopt rules related to the activities listed in this section and the regulation of PHPs, except that any rules adopted relating to PHP licensure under Chapter 58 of the General Statutes and Section 6 of this act shall be adopted by the Department of Insurance.

(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that holds a PHP license issued by the Department of Insurance and that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this section. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:

a. Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and ~~holds a PHP license issued by the Department of Insurance.~~ is not a PLE.

b. Provider-led entity or PLE. – An entity that meets all of the following criteria:

1. A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section or Medicaid and NC Health Choice providers.

2. A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have sufficient experience treating beneficiaries of the North Carolina Medicaid ~~program.~~ program, as determined by the Secretary of DHHS.

~~3. Holds a PHP license issued by the Department of Insurance.~~

...

(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) for four years after the date capitated contracts begin.~~

~~b. Dental services~~.

…

g. The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames."

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

a. Recipients who are dually eligible for Medicaid and ~~Medicare.~~ Medicare for two years after the date capitated contracts begin. 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.~~ As recommended by DHHS in its "Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries" dated January 31, 2017, enrollment of dually eligible recipients shall begin two years after the date capitated contracts begin, may be phased as described in DHHS's January 31, 2017 report, and shall be completed within two years after the date that dually eligible recipients are first enrolled with PHPs.

…

h. Recipients enrolled under the Medicaid Family Planning program.

i. Recipients who are inmates of prisons.

(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~~ No less than three and no more than five 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 ~~12~~ 4 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.

…

(6a) ~~To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act,~~ PHPs shall comply with the requirements of ~~Chapter 58 of the General Statutes.~~ of Part 438 of Title 42 of the Code of Federal Regulations.~~This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations.~~ The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.

b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.

c. Proposed statutory changes necessary to implement this subdivision.

...

~~(9) LME/MCOs. LME/MCOs shall continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin. During this four-year period, the Division of Health Benefits shall continue to negotiate actuarially sound capitation rates directly with the LME/MCOs in the same manner as currently utilized. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits during the four-year period.~~"

SECTION 11. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan ~~amendments~~ amendments, as well as any modifications to these submissions, necessary to accomplish the requirements of this act within the required time frames. If DHHS submits any modification to these submissions, DHHS shall provide notice in accordance with G.S. 108A-54.1A(d1).

(2) Define ~~six~~ regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in Section 1 of this act. Every county in the State must be assigned to a region.

...

(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 shall develop standardized contract terms, to include at a minimum, the following:

...

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. PHPs and hospitals must negotiate mutually acceptable rates, methods, and terms of payment.

d1. A requirement that the negotiated payments to hospitals may not exceed one hundred twenty-five percent (125%) of the fee-for-service Medicaid rate unless specifically approved by DHHS.

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

...

(7a) Require providers enrolling or reenrolling as a Medicaid or NC Health Choice provider to agree to accept ninety percent (90%) of the Medicaid fee-for-service rate for the services they provide to PHP enrollees if the provider has been offered a contract with a PHP but the provider is not under a contract with that PHP, or if the provider is excluded from contracting with the PHP for failure to meet objective quality standards. DHHS shall implement this requirement within 30 days after this subdivision becomes law, unless a waiver by the Centers for Medicare and Medicaid Services is required as provided in 42 C.F.R. 431.55(f). If a waiver is required, DHHS shall implement this requirement upon CMS's approval of that waiver.

...."

PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS

SECTION 12. G.S. 108A-54.1A reads as rewritten:

"§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.

(a) The Department of Health and Human Services 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, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

(b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(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 Medicaid and NC Health Choice and the Fiscal Research Division that the amendment has been posted. For any amendments to the State Plan that add or eliminate an optional service, the notice required by this subsection shall be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval.

(d1) Upon the submission of an amendment to the State Plan or a modification to a previously submitted amendment to the State Plan to the federal government, the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division that the amendment or modification has been submitted.

If the Department determines that an amendment posted on its Web site in accordance with subsection (d) of this section will not be submitted to the federal government, then the Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division upon making that determination.

(e) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

(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 Medicaid and NC Health Choice and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 13. This Part is effective when it becomes law and applies to amendments to the State Plan posted on the Department of Health and Human Services Web site on or after that date.

PART IV. CONFORMING CHANGES TO LME/MCO APPEALS

SECTION 14. G.S. 108D-1 reads as rewritten:

"**§ 108D-1. Definitions.**

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

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).

~~(1)~~(1a) Applicant. – A provider of mental health, intellectual or developmental disabilities, and substance abuse services who is seeking to participate in the closed network of one or more local management entity/managed care organizations.

(2) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about ~~a managed care action.~~an adverse benefit determination.

(4) Department. – The North Carolina Department of Health and Human Services.

(5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(6) Emergency services. – As defined in 42 C.F.R. § 438.114.

(7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local management entity/managed care organization.

(8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).

(9) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3(20c).

~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~

(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.

(12) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department of Health and Human Services and a local management entity to operate a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed

network of one or more local management entity/managed care organizations.

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

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

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

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

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

SECTION 15. G.S. 108D-12(a) reads as rewritten:

"(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than ~~a managed care action.~~an adverse benefit determination. Upon receipt of a grievance, an LME/MCO shall cause a written acknowledgment of receipt of the grievance to be sent by United States mail."

SECTION 16. G.S. 108D-13 reads as rewritten:

"**§ 108D-13. Standard LME/MCO level appeals.**

(a) Notice of ~~Managed Care Action.~~Adverse Benefit Determination. – An LME/MCO shall provide an enrollee with a written notice of ~~a managed care action~~ adverse benefit determination by United States mail as required under 42 C.F.R. § 438.404. The notice of action will employ a standardized form included as a provision in the contracts between the LME/MCOs and the Department of Health and Human Services.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~adverse benefit determination. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal in writing by United States mail.

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

(d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f)."

SECTION 17. G.S. 108D-14 reads as rewritten:

"**§ 108D-14. Expedited LME/MCO level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for an expedited appeal of ~~a managed care~~

~~action~~ an adverse benefit determination no later than 30 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

...

(d) Notice of Resolution. – If the LME/MCO grants a request for an expedited LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this ~~three day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~section or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

...."

SECTION 18. G.S. 108D-15 reads as rewritten:

"**§ 108D-15. Contested case hearings on disputed managed care actions.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

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

...

(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

...

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

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

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

(3) A preprinted statement that indicates that the enrollee would like to appeal a specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

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

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

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

...

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

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

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

(3) Failed to use proper procedure.

(4) Acted arbitrarily or capriciously.

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

...."

SECTION 19. This Part is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

PART V. EFFECTIVE DATE

SECTION 20. Except as otherwise provided, this act is effective when it becomes law.

Senate Committee on Health Care

June 15 – Room 643 – 10:00 AM

Speakers

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Chip Baggett	NCMS HB 403
Cody Hand	NCHA
Ken Lewis	NCAHP
Mary Hooper	NCCCP HB403
Brian Perkins	Alliance BHC HB 403
SANDY SANDS	MCNA HB 403
[redacted]	[redacted]
Andy Ellen	NC Retail Merchants 403
[redacted]	[redacted]

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 15, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Blankenship	Cone Health
Susanna Davis	DSHR
Wendy Kelly	Forum Carolina
Kelly Vogel	KV Strategics
Cody Hand	NCHA
Skippy	NNA
Doug Heron	Duke
Christine Cox	Wakemed
Sue Ann Ford	NCMS
	SA
DA	SA
Amanda Donovan	KTS
Andy Ellen	NCPA
Duke Richard	DHHS
Amanda	
Dad	CCL

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 15, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Mike Jones	ACP
Bill Styles	Office of the State Auditor
Tim Hoegemeyer	" " " " "
Sarah Skinner	" "
Alex Parker	" "
Jennifer Myers	" "
Daniel W Jones	[illegible]
[illegible]	DHHS
[illegible]	OP
Amy Fick	30 Pic
Gary Hooker Jr.	ACHFA
[illegible]	[illegible]
Will Morgan	MFS
JOE LANIER	TSS
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	MWC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 15, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
DANIEL BALM	TROUTMAN SANDERS
Ann Rodriguez	NC Council of Comm Programs
Phoebe Landon	MWC
LT McCrimmon	DHHS
B Popkin	DHHS
CSH	CSH
Robin Huffman	NC Psychiatric Assoc
Jon Carr	NC Veterinary Medical Assn.
[illegible]	[illegible]
Kris Lawing	PTA
Chris Baggett	ovations
Dana Simpson	SIA
Daniel Ambrose	UCB
Rick Zechini	Williams Mullen
David Ferrell	UB
TAYLOR GRIFFIN	NCAHP
Johanna Reese	NCAHC
Andy Munn	NVA
Scott Luster	Kaiser

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 15, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Chris McClure	BP
GERRY COHEN	NM
John DelGuerno	Brubaker + Assoc
Sarah Bales	" "
Debbie Clary	NCSP
Michelle Fiorier	SML
Ken Melton	K.M.A
TRACY GALVAPP	AHC
Julia Adams Scheurich	OCGR
Kelly Hatcher	NC CFTF
Michelle Brooks	ECU
David Collins	SEANC
Ed Immler	BJP
Nick Younger	Gov. Office
Sarah McQuillan	KCNC
Abbey Ackiss	NC Chamber
JEFF BARNHART	MWC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 15, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Ashley Perkins	Perkins Law
Rachel Beach	PBLaw
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
David Kolbaugh	NC Board of Nursing
Jessi Gaugney	DHHS
Frank Hill	PSG
Morgan Dunn	Walk West
Caroline Perry	Walk West
Lindsay Robinson	PPSAT
Adam Sholar	NCHCFA
Jim Harrell,	[illegible]
Ken Lewis	NCAHP
JPeters	CSS
Joyce Peters	CSS
JC Pongan	CSS
Gina Cammarano	Family Cammarano, P.A.

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 15, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Kari Barsness	Gateway Health
Penny Boyette	S&G
Mary Hooper	NCCCP
Ann Rodriguez	NC Council of Comm Programs
Bradford Sneeden	NCDOJ
Robert PASchal	NCDOJ

09-21-201

Senate Committee on Health Care

June 15 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Lisa Ward	NC Dental Society
Alec Parker	NC Dental Society

Senate Committee on Health Care

June 15 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Tom Bean	EDF

Senate Committee on Health Care
Thursday, June 22, 2017 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 22, 2017 in Room 643 of the Legislative Office Building. Eighteen members were present.

Senator Louis M. Pate, Jr. presided.

Senator Pate welcomed everyone and recognized the Senate Sergeant-at-Arms --- John Enloe, Jim Hamilton, and Tom Burroughs. He also recognized the Senate Pages --- Katie Long of Wake County, Wilson Matsuo of Wake County, Olivia Bennett of Chatham County, Parker Davis of Wilkes County, Lucas Boyd of Cumberland County, Emily Kohn of Durham County, Tallulah Cloos of Buncombe County, and Lara Kowaloyk of Orange County.

Senator Hise presented HB 156 Medicaid PHP Licensure/Food Svcs State Bldgs. After discussion on the bill, Senator Hise presented an amendment to House Bill 156. Senator Tucker motioned for an unfavorable report as to the bill, but favorable as to Senate committee substitute bill, and House Bill 156 as amended was referred to Committee on Rules and Operations of the Senate. The title of HB 156 was changed from Eyeglasses Exemption From Medicaid Capitation to Medicaid PHP Licensure/Food Service State Buildings.

Senator Krawiec presented HB 277 Naturopathic Study. After discussion on the bill Senator Krawiec presented an amendment to House Bill 277. Senator Don Davis motioned for an unfavorable report as to the bill, but favorable as to Senate committee substitute bill, and House Bill 277 as amended was referred to Committee on Rules and Operations of the Senate. The title of House Bill 277 was changed from Expand Rx Drug Abuse Advisory Committee to Naturopathic Study.

The meeting adjourned at 10:58 AM.

Senator Louis M. Pate, Jr.
Presiding

Sinclaire Owen, Committee Clerk

Senate Committee on Health Care
Thursday, June 22, 2017, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 156	Medicaid PHP Licensure/Food Svcs State Bldgs.	Representative McNeill Representative Lambeth Representative Dobson Representative Brisson
HB 277	Naturopathic Study.	Representative Faircloth Representative R. Turner Representative Murphy Representative Ross

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Thursday, June 22, 2017

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

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

HB **156** Eyeglasses Exemption From Medicaid Capitation.

Draft Number:	H156-PCS10390-TRf-8
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

HB **277** Expand Rx Drug Abuse Advisory Committee.

Draft Number:	H277-PCS30421-SH-28
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Ralph Hise will handle HB 156
Senator Joyce Krawiec will handle HB 277

HOUSE BILL 156

Short Title:	Eyeglasses Exemption From Medicaid Capitation.	(Public)
Sponsors:	Representatives McNeill, Lambeth, Dobson, and Brisson (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

February 22, 2017

A BILL TO BE ENTITLED

AN ACT TO EXEMPT THE FABRICATION OF EYEGLASSES FROM CAPITATED PREPAID HEALTH PLAN CONTRACTS UNDER MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1. Subsection (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, reads as rewritten:

"(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) for four years after the date capitated contracts begin.

b. Dental services.

c. Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

d. Audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individuals contracted with Local Education Agencies.

e. Services provided directly by a Children's Developmental Services Agency (CDSA) or by a provider under contract with a CDSA if the service is authorized through the CDSA and is included on the child's Individualized Family Service Plan.

f. Services for Medicaid program applicants during the period of time prior to eligibility determination.

g. <u>The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames.</u>"

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

HOUSE BILL 156:
Medicaid PHP Licensure/Food Svcs State Bldgs.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 21, 2017
Introduced by:	Reps. McNeill, Lambeth, Dobson, Brisson	**Prepared by:**	Jennifer Hillman* Staff Attorney
Analysis of:	Amendment to First Edition H156-ATRf-2		

OVERVIEW: Sections 1 through 3 of the amendment to House Bill 156 would create a Prepaid Health Plan (PHP) Licensure Act governing the Department of Insurance's licensure of Medicaid PHPs as part of Medicaid transformation. Sections 4 through 6 of the amendment would allow the Department of Health and Human Services (DHHS) to operate or contract for the operation of food services at certain State properties or facilities.

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, which is currently awaiting approval by the Centers for Medicare and Medicaid Services (CMS). S.L. 2015-245 requires PHPs to hold a PHP license in order to operate.

Article 3 of Chapter 111 of the General Statutes requires State agencies, upon the request of DHHS, to give preference to blind persons for food services operations on State property.

BILL ANALYSIS:

Sections 1 through 3 pertain to the licensure of Medicaid PHPs by the Department of Insurance.

Section 1 of the amendment would enact Article 93 of Chapter 58 of the General Statutes – the Prepaid Health Plan Licensing Act (PHP Licensing Act). The PHP Licensing Act provides the requirements for obtaining a PHP license as well as requirements for maintaining that license. Licenses would be granted by the Commissioner of the Department of Insurance. Key components of the new Article 93 include the following:

- In order to obtain a license, an entity would be required to make an application to the Department of Insurance and pay an application fee not to exceed $2,000.
- Licensed health organizations would not be required to file an application or pay the application fee but would be able to obtain a license upon showing that the licensed health organization meets the requirements of Article 93 of the General Statutes. The new Article 93 defines a licensed heath organization as one of the following:
    - A health maintenance organization licensed under Article 67 of Chapter 58.
    - A full service corporation licensed under Article 65 of Chapter 58.

Karen Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- An insurer under this Chapter that is required by the Commissioner of Insurance to use the NAIC Health Annual Statement Blank when filing the annual statement in accordance with G.S. 58-2-165.

- The term "licensed health organization" does not include an insurer that (i) is licensed under this Chapter as either a life or health insurer or as a property or casualty insurer and (ii) is otherwise subject to either life or property and casualty risk based capital requirements.
- The PHP license would be issued on an annual basis. The fee for the license could be no more than $5,000.
- The new Article 93 prescribes the investments a PHP could make, the approval requirements for exclusive management or custodial agreements, and the examinations that may be made by the Commissioner of Insurance.
- The new Article 93 would require PHPs to have a plan for protection against insolvency, as well as a plan for handling insolvency, approved by the Commissioner of Insurance. PHPs would also be required to maintain a minimum capital and surplus equal to the greater of one million dollars or the amount required under the risk-based capital provisions of Chapter 58. All PHPs would be required to make a deposit of at least $500,000 to be administered in accordance with Article 5 of Chapter 58. The amount could be higher, as determined by the Commissioner of Insurance.
- The new Article 93 outlines actions the Commissioner of Insurance would be able to take if the PHP is in a hazardous financial condition. The new Article 93 also outlines the circumstances under which the Commissioner could suspend or revoke a PHP license, or take any other action against a PHP described in Article 93, and would require the Commissioner to consult with the Secretary of DHHS before taking such actions.
- The new Article 93 also addresses the confidentiality of information shared between the Department of Insurance and DHHS
- The new Article 93 specifies the other provisions of Chapter 58 that are applicable to the operation of PHPs.

Sections 2 and 3 of the amendment would make conforming changes in Chapter 58.

Sections 4 through 6 of the amendment pertain to the operation of food services at certain State properties or facilities.

Section 4 of the amendment amends Article 3 of Chapter 111, which governs the operations of vending facilities on State property, to add a new section that would allow DHHS to operate or contract for the operation of food services at state properties or facilities that are allocated to the Department of Administration or the Department of Insurance. The net proceeds of these operations would go to the Division of Services for the Blind to be used to support programs that enable blind and visually impaired people to live more independently. This new section creates an exemption to the requirement that State agencies, upon the request of DHHS, give preference to blind persons for food services operations on State property. This exemption is similar to the exemption that already exists in statute for the Department of Natural and Cultural Resources and the Department of the State Treasurer.

Section 5 of the amendment amends the statute pertaining to the sale of merchandise or services by governmental units to exempt the operation of food and vending services under Article 3 of Chapter 111 of the General Statutes from the prohibition of governmental entities operating restaurants, cafeterias, or

other eating places in State buildings. The exemption created in this section broadens an existing exemption for DHHS in the statute.

Section 6 of the amendment amends the statute pertaining to the State's lease or sale of real property for less than fair market value to specify that the statute does not apply to leases entered into by DHHS for the operation of food and vending service under Article 3 of Chapter 111 of the General Statutes.

Section 7 of the amendment would sunset the provisions of Section 4 through 6 after five years.

EFFECTIVE DATE: Sections 4 through 6 of this act would be effective when the act becomes law and would expire five years after that date. The remainder of this act would be effective when it becomes law.

**Amy Jo Johnson, Staff Attorney in the Legislative Drafting Division, substantially contributed to this summary.*

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 156

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

H156-ATRf-2 [v.5]

Amends Title [YES]
First Edition

Date June 22 ,2017

Senator Hise

moves to amend the bill on page 1, lines 1 through 30, by rewriting the lines to read:

"A BILL TO BE ENTITLED

AN ACT TO REQUIRE MEDICAID PREPAID HEALTH PLANS TO OBTAIN A LICENSE FROM THE DEPARTMENT OF INSURANCE AND TO MAKE CHANGES PERTAINING TO THE OPERATION OF FOOD SERVICES AT CERTAIN STATE PROPERTIES AND FACILITIES.

The General Assembly of North Carolina enacts:

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

"Article 93.

"Prepaid Health Plan Licensing Act.

"**§ 58-93-1. Short title.**

This Article may be cited as the Prepaid Health Plan Licensing Act.

"**§ 58-93-2. Definitions.**

The following definitions apply in this Article:

(1) DHHS. – The North Carolina Department of Health and Human Services.

(2) Enrollee. –A beneficiary enrolled to receive Medicaid or NC Health Choice services through a Prepaid Health Plan.

(3) Governing body. – The board of directors, trustees, partners, managers, or other individuals who are legally responsible for the governance of an entity.

(4) Health care services. – Medicaid or NC Health Choice services provided by a Prepaid Health Plan under a capitated contract with DHHS.

(5) Insolvent or insolvency. – A circumstance that occurs when a Prepaid Health Plan has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(6) Licensed health organization. – A licensed health organization includes all of the following:

a. A health maintenance organization licensed under Article 67 of this Chapter.

b. A full service corporation licensed under Article 65 of this Chapter.

c. An insurer under this Chapter that is required by the Commissioner to use the NAIC Health Annual Statement Blank when filing the annual statement in accordance with G.S. 58-2-165.

The term "licensed health organization" does not include an insurer that (i) is licensed under this Chapter as either a life or health insurer or as a property or casualty insurer and (ii) is otherwise subject to either life or property and casualty risk-based capital requirements.

(7) Prepaid Health Plan or PHP. – As defined in subdivision (2) of Section 4 of S.L. 2015-245, as amended. For the purposes of 11 U.S.C. § 109(b)(2) and 11 U.S.C. § 109(d) only, a PHP is a domestic insurance company.

(8) Working capital. – The excess of current assets over current liabilities. The only borrowed funds that may be included in working capital must be funds that are repayable only from net earned income and must be repayable only with the advance permission of the Commissioner.

"**§ 58-93-3. Maximize federal reimbursement.**

The Commissioner shall work with DHHS to maximize federal reimbursement of the Department's expenses in administering this Article to the extent that federal reimbursement is allowed under federal law.

"**§ 58-93-4. Commissioner use of consultants and other professionals.**

(a) The Commissioner may contract with consultants and other professionals to expedite and complete the application process, examinations, and other regulatory activities required under this Article. Costs of contracts entered into under this section shall be reimbursed by the applicant or licensee.

(b) Contracts under this section for financial, legal, examination, and other services shall not be subject to any of the following:

(1) G.S. 114-2.3.

(2) G.S. 147-17.

(3) Articles 3, 3C, and 8 of Chapter 143 of the General Statutes and any rules and procedures adopted under those Articles concerning procurement, contracting, and contract review.

"**§ 58-93-5. Licensing.**

(a) Any entity may apply to the Commissioner for a license to operate a PHP in compliance with this Article.

(b) Each license application shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall be set forth or be accompanied, at a minimum, by all of the following:

(1) A copy of the organizational documents, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments.

(2) A copy of the bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

(3) A list of the names, addresses, official positions, and biographical affidavits of the persons who are to be responsible for the conduct of the affairs of the

applicant, including all members of the governing body, the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association, or the managers in the case of a limited liability company. This list shall be accompanied by a completed release of information for each of these individuals on forms acceptable to the Commissioner.

(4) A disclosure identifying all affiliates, including a description of any management, service, or cost-sharing arrangement between an affiliate and the applicant.

(5) The name and address of the registered agent of the applicant.

(6) A detailed plan of operation.

(7) The names and addresses of the applicant's qualified actuary and external auditors.

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this Article.

(9) A financial feasibility study that includes (i) detailed enrollment projections, (ii) a projection of balance sheets, (iii) cash flow statements that show any capital expenditures, purchases and sales of investments, and deposits with the State, (iv) anticipated income and anticipated expense statements covering the start of operations through the period in which the PHP is anticipated to have had net income for at least one year, and (v) a statement as to the sources of working capital as well as any other sources of funding.

(10) If not domiciled in this State, a power of attorney duly executed by the applicant appointing the Commissioner, the Commissioner's successors in office, and duly authorized deputies as the true and lawful attorney of the applicant in and for this State, upon whom all lawful process in any legal action or proceeding against the PHP on a cause of action arising in this State may be served.

(11) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 58-93-50.

(12) The plan for handling an insolvency as required by G.S. 58-93-55.

(13) Other information as the Commissioner may require in order to make the determinations required in G.S. 58-93-10.

(c) Any person that is already a licensed health organization in this State under this Chapter shall be recognized as a PHP under this Article and shall be issued a PHP license upon the licensed health organization's demonstration to the Commissioner compliance with this Article. A licensed health organization shall not be required to file a PHP application, pay a PHP application fee, or provide the notice required by subsection (d) of this section as a condition of receipt of a PHP license. Unless otherwise exempted, a licensed health

organization shall be subject to the remaining requirements of this Article, including deposit, minimum capital and surplus, and working capital requirements.

(d) A PHP shall file a notice describing any significant modification of the operation set out in the information required by subsection (b) of this section for approval by the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, the modification shall be deemed to be approved. Every PHP shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.

(e) The Commissioner shall regularly provide DHHS with information and documentation related to its licensing and regulation of PHPs, including licenses, examination results, penalties imposed, or other actions taken in regards to PHPs.

"**§ 58-93-10. Issuance and continuation of license.**

(a) Before issuing or continuing any PHP license, the Commissioner of Insurance may make any examination as the Commissioner deems expedient. The Commissioner shall issue a license upon the payment of the application fee prescribed in G.S. 58-93-14 and upon being satisfied on all of the following points:

(1) The applicant has complied with the application requirements of G.S. 58-93-5.

(2) The applicant has a minimum capital and surplus equal to or greater than that required by G.S. 58-93-50(b).

(3) The amounts provided as working capital are repayable only out of earned income in excess of amounts paid and payable for operating expenses and expenses of providing services and such reserve as the Department deems adequate.

(4) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the license and that the PHP is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. Such working capital shall initially be a minimum of one million five hundred thousand dollars ($1,500,000) or a higher amount as the Commissioner shall determine to be adequate.

(5) The person or persons who will manage the PHP have adequate expertise, experience, and character.

(b) A license shall be denied only after compliance with the requirements of G.S. 58-93-75.

"**§ 58-93-14. Fees.**

The Commissioner shall establish an application fee not to exceed two thousand dollars ($2,000) for entities filing an application to be licensed as a PHP under this Article. The Commissioner shall establish an annual PHP license continuation fee not to exceed five thousand dollars ($5,000). The PHP license shall continue in full force and effect subject to timely payment of the annual PHP license continuation fee in accordance with G.S. 58-6-7(c) and subject to any other provisions of this Chapter applicable to PHPs.

"**§ 58-93-15. Deposits.**

(a) All deposits required by this section shall be administered in accordance with the provisions of Article 5 of this Chapter.

(b) The Commissioner shall require a minimum deposit of five hundred thousand dollars ($500,000) or such higher amount as the Commissioner determines to be necessary for the protection of enrollees.

(c) For licensed health organizations, the deposit required by this section is in addition to any other deposit required by the Commissioner.

(d) All deposits made pursuant to this section shall not be subject to G.S. 58-62-95.

"**§ 58-93-20. Management and exclusive agreements; custodial agreements.**

(a) No PHP shall enter into an exclusive management or custodial agreement unless the agreement is first filed with the Commissioner and approved under this section within (i) 45 days after filing or (ii) a reasonable extended period as specified by notice from the Commissioner given within a 45-day period after filing.

(b) The Commissioner shall disapprove an agreement submitted under subsection (a) of this section if the Commissioner determines that the agreement does any of the following:

(1) Subjects the PHP to excessive charges.

(2) Extends for an unreasonable period of time.

(3) Does not contain fair and adequate standards of performance.

(4) Enables persons under the contract to manage the PHP who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the PHP with due regard for the interests of its enrollees, creditors, or the public.

(5) Contains provisions that impair the interests of the PHP's enrollees, creditors, or the public.

"**§ 58-93-25. Fiduciary responsibilities.**

Any director, officer, trustee, manager, or partner of a PHP who receives, collects, disburses, or invests funds in connection with the activities of the PHP shall be responsible for those funds in a fiduciary relationship to the enrollees and to the State.

"**§ 58-93-30. Statements filed with Commissioner.**

Every PHP subject to this Article is subject to G.S. 58-2-165.

"**§ 58-93-35. Investments.**

(a) With the exception of investments made in accordance with subsection (b) of this section, the funds of a PHP shall be invested or maintained only in securities, other investments, or other assets permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commissioner may permit.

(b) A PHP may, with the Commissioner's prior approval, do any of the following:

(1) Invest its funds to purchase, lease, construct, renovate, operate, or maintain (i) a hospital, (ii) a medical facility, (iii) ancillary equipment of a hospital or medical facility, or (iv) any property as may reasonably be required for its principal office or for other purposes as may be necessary in the transaction of the business of the PHP.

(2) Make loans to a medical group under contract with the PHP in furtherance of the PHP's program or the making of loans to a corporation or corporations under the PHP's control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees.

(c) The Commissioner shall not allow any investment if the Commissioner determines the investment would substantially and adversely affect the financial soundness of the PHP and endanger its ability to meet its obligations.

"**§ 58-93-40. Examinations.**

The Commissioner may make an examination of the affairs of any PHP as often as the Commissioner determines it to be necessary for the protection of the interests of the enrollees or the State but not less frequently than once every five years. Examinations shall otherwise be conducted under G.S. 58-2-131 through G.S. 58-2-134.

"**§ 58-93-45. Hazardous financial condition.**

(a) Whenever the financial condition of any PHP indicates a condition such that the continued operation of the PHP might be hazardous to its enrollees, creditors, the general public, or the State, the Commissioner may order the PHP to take action as may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

(1) Reduce the total amount of present and potential liability for health care services by reinsurance.

(2) Reduce the volume of new business being accepted.

(3) Reduce the expenses by specified methods.

(4) Suspend or limit the writing of new business for a specified period of time.

(5) Require an increase to the PHP's capital and surplus by contribution.

(b) The Commissioner may consider any or all of the standards in G.S. 58-30-60(b) when determining whether the continued operation of a PHP is hazardous to its enrollees, creditors, the general public, or the State.

(c) The remedies under subsection (a) of this section are in addition to, and not in lieu of, the remedies and measures available to the Commissioner under the provisions of Article 30 of this Chapter.

(d) The Commissioner shall notify the Secretary of DHHS prior to taking any action against a PHP under this section.

"**§ 58-93-50. Protection against insolvency.**

(a) The Commissioner shall require deposits in accordance with the provisions of G.S. 58-93-15.

(b) Each PHP shall maintain a minimum capital and surplus equal to the greater of one million dollars ($1,000,000) or the amount required under the risk-based capital provisions of Article 12 of this Chapter.

(c) Every PHP shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Commissioner. In determining the adequacy of such a plan, the Commissioner may consider all of the following:

(1) A reinsurance agreement preapproved by the Commissioner covering excess loss, stop loss, or catastrophes. The agreement must provide that the

Commissioner will be notified no less than 60 days prior to cancellation or reduction of coverage.

(2) Any other arrangements offering protection against insolvency that the Commissioner may require.

"**§ 58-93-55. Continuation of health care services.**

(a) The Commissioner shall require that each PHP have a plan for handling insolvency. The plan must allow for health care services to be provided to enrollees until the PHP's enrollees whose enrollment in a PHP is not voluntary are enrolled in another PHP. In considering the plan, the Commissioner may require any of the following:

(1) Insurance to cover the expenses to be paid for enrollee health care services after an insolvency.

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PHP's insolvency until the PHP's enrollees whose enrollment in a PHP is not voluntary are enrolled in another PHP.

(3) Insolvency reserves.

(4) Letters of credit acceptable to the Commissioner.

(5) Any other arrangements to assure that health care services are provided to enrollees as specified in this section.

"**§ 58-93-60. Incurred but not reported claims.**

(a) Every PHP shall, when determining liability, include an amount estimated in the aggregate to provide for (i) any unearned capitation payment, (ii) the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which the PHP is or may be liable, and (iii) the expense of adjustment or settlement of these claims.

(b) Liabilities shall be computed in accordance with rules adopted by the Commissioner based upon rules applicable to health maintenance organizations adjusted for reasonable consideration of the ascertained experience and character of the PHP.

"**§ 58-93-65. Suspension or revocation of license.**

(a) The Commissioner may suspend or revoke a PHP license if the Commissioner finds that the PHP meets any of the following:

(1) Is operating significantly in contravention of its organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 58-93-5, unless amendments to such submissions have been filed with and approved by the Commissioner.

(2) Is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(3) Is operating in a manner that would be hazardous to its enrollees or to the State.

(4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PHP or with any order issued by the Commissioner after notice and opportunity for a hearing.

(5) Has knowingly published or made to the Department, to DHHS, or to the public any false statement or report.

(b) A license shall be suspended or revoked only after compliance with G.S. 58-93-75.

(c) When a PHP license is suspended, the PHP shall not, during the suspension, enroll any additional enrollees, except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation.

(d) When a PHP license is revoked, the PHP shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PHP. The PHP shall engage in no advertising or solicitation. The Commissioner may, by written order, permit such further operation of the PHP as the Commissioner may find to be in the best interest of enrollees and the State of North Carolina.

(e) The Commissioner shall consult with the Secretary of DHHS prior to taking any action against a PHP under this section.

"**§ 58-93-70. Rehabilitation or liquidation of PHP.**

Any rehabilitation or liquidation of a PHP shall be deemed to be the rehabilitation or liquidation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to Article 30 of this Chapter. The Commissioner may apply for an order directing the Commissioner to rehabilitate or liquidate a PHP upon one or more grounds set out in Article 30 of this Chapter or when it is the opinion of the Commissioner that the continued operation of the PHP would be hazardous either to the enrollees or to the State. Priority shall be given to DHHS's claims over all other claims in G.S. 58-30-220, except for claims in G.S. 58-30-220(1).

"**§ 58-93-75. Administrative procedures.**

(a) When the Commissioner has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, notification shall be given to the PHP in writing. This notice shall specifically state the grounds for denial, suspension, or revocation and shall set a date for a hearing on the matter at least 30 days after notice is given.

(b) After such hearing, or upon the failure of the PHP to appear at such hearing, the Commissioner shall take action as is deemed advisable and issue written findings which shall be mailed to the PHP. The Commissioner shall provide DHHS with an explanation of the action taken and a copy of the written findings.

(c) The action of the Commissioner taken under subsection (b) of this section shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Commissioner in whole or in part.

(d) The provisions of Chapter 150B of the General Statutes of this State shall apply to proceedings under this section to the extent that they are not in conflict with this section.

"**§ 58-93-80. Penalties and enforcement.**

(a) The Commissioner may, in addition to or in lieu of suspending or revoking a license under G.S. 58-93-65, proceed under G.S. 58-2-70, provided that the PHP has reasonable time to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Violation of this Article or any other provision of this Chapter that expressly applies to PHPs is a Class 1 misdemeanor.

(c) If the Commissioner shall for any reason have cause to believe that any violation of this Article or any other provision of this Chapter that expressly applies to PHPs has occurred or is threatened, the Commissioner may give notice to the PHP and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation. If notice is given under this subsection, a copy of the notice shall be provided to the Secretary of DHHS. The Secretary of DHHS or the Secretary's designee may be present at any proceedings under this subsection.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances.

(d) The Commissioner may issue an order directing a PHP or a representative of a PHP to cease and desist from engaging in any act or practice in violation of the provisions of this Article or any other provision of this Chapter that expressly applies to PHPs.

Within 30 days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices have occurred that are in violation of this Article or any other provision of this Chapter that expressly applies to PHPs. The hearing shall be conducted under Article 3A of Chapter 150B of the General Statutes, and judicial review shall be available as provided by Article 4 of Chapter 150B of the General Statutes.

(e) In the case of any violation of the provisions of this Article or any other provision of this Chapter that expressly applies to PHPs, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued under subsection (d) of this section, the Commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief, in the Superior Court of Wake County.

(f) The Commissioner shall consult with the Secretary of DHHS prior to taking any action against a PHP under this section.

"**§ 58-93-85. Confidentiality of information.**

(a) All applications, filings, and reports required under this Article shall be treated as public documents unless otherwise determined by the Commissioner to be proprietary information.

(b) Information shared between the Department and DHHS under this Article is confidential and not open to public inspection under G.S. 132-6, unless the information is considered a public record under G.S. 132-1 or is otherwise subject to disclosure under the provisions of Chapter 132 of the General Statutes.

(c) Information shared between the Department and DHHS under this Article that is not open to public inspection shall not be disclosed to any person unless otherwise agreed to by both the Commissioner and the Secretary of DHHS.

"**§ 58-93-90. Statutory construction and relationship to other laws.**

(a) Except as otherwise provided in this Article, provisions of this Chapter to not apply to either of the following:

(1) A PHP that is not a licensed health organization.

(2) A PHP that is a licensed health organization in regards to activities that relate solely to the PHP's Medicaid or NC Health Choice operations.

(b) Nothing in this section shall limit the Commissioner's authority over a PHP that is a licensed health organization in relation to any activities that do not relate solely to the PHP's Medicaid or NC Health Choice operations.

"**§ 58-93-91. Rules.**

The Commissioner may adopt rules to carry out the provisions of this Article.

"**§ 58-93-92. Other laws applicable to PHPs.**

The following provisions of this Chapter are applicable to PHPs in the manner in which they are applicable to insurers:

(1) G.S. 58-2-125, Authority over all insurance companies; no exemptions from license.

(2) G.S. 58-2-131, Examinations to be made; authority, scope, scheduling, and conduct of examinations.

(3) G.S. 58-2-132, Examination reports.

(4) G.S. 58-2-133, Conflict of interest; cost of examinations; immunity from liability.

(5) G.S. 58-2-134, Cost of certain examinations.

(6) G.S. 58-2-150, Oath required for compliance with law.

(7) G.S. 58-2-155, Investigation of charges.

(8) G.S. 58-2-160, Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.

(9) G.S. 58-2-162, Embezzlement by insurance agents, brokers, or administrators.

(10) G.S. 58-2-165, Annual, semiannual, monthly, or quarterly statements to be filed with Commissioner.

(11) G.S. 58-2-185, Record of business kept by companies and agents; Commissioner may inspect.

(12) G.S. 58-2-190, Commissioner may require special reports.

(13) G.S. 58-2-195, Commissioner may require records, reports, etc., for agencies, agents, and others.

(14) G.S. 58-2-200, Books and papers required to be exhibited.

(15) G.S. 58-2-205, CPA audits of financial statements.

(16) G.S. 58-7-21, Credit allowed a domestic ceding insurer.

(17) G.S. 58-7-26, Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of G.S. 58-7-121.

(18) G.S. 58-7-30, Insolvent ceding insurer.

(19) G.S. 58-7-31, Life and health reinsurance agreements.

(20) G.S. 58-7-46, Notification to Commissioner for president or chief executive officer changes.
(21) G.S. 58-7-73, Dissolution of insurers.
(22) G.S. 58-7-160, Investments unlawfully acquired.
(23) G.S. 58-7-162, Allowed or admitted assets.
(24) G.S. 58-7-163, Assets not allowed.
(25) G.S. 58-7-165, Eligible investments.
(26) G.S. 58-7-167, General qualifications.
(27) G.S. 58-7-168, Authorization of investment.
(28) G.S. 58-7-170, Diversification.
(29) G.S. 58-7-172, Cash and deposits.
(30) G.S. 58-7-173, Permitted insurer investments.
(31) G.S. 58-7-179, Mortgage loans.
(32) G.S. 58-7-180, Chattel mortgages.
(33) G.S. 58-7-183, Special consent investments.
(34) G.S. 58-7-185, Prohibited investments and investment underwriting.
(35) G.S. 58-7-188, Time limit for disposal of ineligible property and securities; effect of failure to dispose.
(36) G.S. 58-7-192, Valuation of securities and investments.
(37) G.S. 58-7-193, Valuation of property.
(38) G.S. 58-7-197, Replacing certain assets; reporting certain liabilities.
(39) G.S. 58-7-200, Investment transactions.
(40) G.S. 58-7-205, Derivative transactions.
(41) Article 5, Deposits and Bonds by Insurance Companies.
(42) Part 7 of Article 10, Annual Financial Reporting.
(43) Article 12, Risk-Based Capital Requirements.
(44) Article 13, Asset Protection Act.
(45) Article 19, Insurance Holding Company System Regulatory Act."

SECTION 1.(b) If any provision of Section 1 of this act or its application is held invalid, the invalidity does not affect other provisions or applications of Section 1 of this act that can be given effect without the invalid provisions or application, and, to this end, the provisions of this act are severable.

SECTION 2. G.S. 58-62-21(c) is amended by added by adding a new subdivision to read:

"**§ 58-62-21. Coverage and limitations.**

...

(c) This Article does not provide coverage for:

...

(11) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits under the State's Medicaid program or NC Health Choice program."

SECTION 3. G.S. 58-30-220 reads as rewritten:

"**§ 58-30-220. Priority of distribution.**

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds shall be retained for payment before the members of the next class receive any payment. No subcategories shall be established within the categories in a class. The order of distribution of claims shall be:

(1) The receiver's expenses for the administration and conservation of assets of the insurer.

(2) Claims or portions of claims for benefits under policies and for losses incurred, including claims of third parties under liability policies; claims of HMO enrollees and HMO enrollees' beneficiaries; claims for unearned premiums; claims for funds or consideration held under funding agreements, as defined in G.S. 58-7-16; claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values; and claims of domestic and foreign guaranty associations, including claims for the reasonable administrative expenses of domestic and foreign guaranty associations; but excluding claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements, claims of other insurers for subrogation, and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages.

(2a) For HMOs, claims of providers and participating providers, as defined in G.S. 58-67-5(h) and G.S. 58-67-5(1)[(l)], who are obligated by statute, agreement, or court order to hold enrollees harmless from liability for services provided and covered by an HMO.

(2b) For prepaid health plans licensed under Article 93, claims of providers who are obligated by statute, agreement, or court order to hold enrollees harmless, except for copayments and deductibles, from liability for health care services provided and covered by a Prepaid Health Plan.

(3) Claims of the federal or any state or local government or taxing authority, including claims for taxes.

(4) Compensation actually owing to employees other than officers of the insurer for services rendered within three months before the commencement of a delinquency proceeding against the insurer under this Article, but not exceeding one thousand dollars ($1,000) for each employee. In the discretion of the Commissioner, this compensation may be paid as soon as practicable after the proceeding has been commenced. This priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of those employees.

(5) Claims of general creditors, including claims of insurance pools, underwriting associations, or those arising out of reinsurance agreements; claims of other insurers for subrogation; and claims of insurers for payments and settlements under uninsured and underinsured motorist coverages."

SECTION 4. Article 3 of Chapter 111 of the General Statutes is amended by adding a new section to read:

"**§ 111-47.4. Food service at certain State properties or facilities.**

Notwithstanding any other provision of this Article, the Department of Health and Human Services may operate or contract for the operation of food or vending services at State property or State facilities allocated to the Department of Administration or the Department of Insurance. The net proceeds of revenue generated by food and vending services at such State property or State facilities by the Department of Health and Human Services or a vendor with whom the Department of Health and Human Services has contracted, shall be credited to the Division of Services for the Blind of the Department of Health and Human Services for the purposes specified in G.S. 111-43. Nothing in this section shall be construed to remove an exemption granted in G.S. 111-42(c)."

SECTION 5. G.S. 66-58(c)(4) reads as rewritten:

"**§ 66-58. Sale of merchandise or services by governmental units.**

...

(c) The provisions of subsection (a) shall not prohibit:

...

(4) ~~The operation of lunch counters by the Department of Health and Human Services as blind enterprises of the type operated on January 1, 1951, in State buildings in the City of Raleigh.~~ The operation of food and vending services under Article 3 of Chapter 111 of the General Statutes.

...

...."

SECTION 6. G.S. 146-29.1 is amended by adding a new subsection to read:

"(i) This section shall not apply to leases entered into by the Department of Health and Human Services for the operation of food and vending services under Article 3 of Chapter 111 of the General Statutes."

SECTION 7. Sections 4 through 6 of this act are effective when this act becomes law and expire five years after that date. The remainder of this act is effective when it becomes law.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 277

Short Title:	Expand Rx Drug Abuse Advisory Committee.	(Public)
Sponsors:	Representatives Faircloth, R. Turner, Murphy, and Ross (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

March 8, 2017

A BILL TO BE ENTITLED

AN ACT ADDING ONE REPRESENTATIVE OF THE DIVISION OF ADULT CORRECTION AND JUVENILE JUSTICE OF THE DEPARTMENT OF PUBLIC SAFETY TO THE PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. Subsections (m) through (q) of Section 12F.16 of S.L. 2015-241 are codified as G.S. 90-113.75A and read as rewritten:

"**§ 90-113.75A. Prescription Drug Abuse Advisory Committee; statewide strategic plan.**

(a) There is hereby created the Prescription Drug Abuse Advisory Committee, to be housed in and staffed by the ~~Department of Health and Human Services (DHHS).~~Department. The Committee shall develop and, through its members, implement a statewide strategic plan to combat the problem of prescription drug abuse. The Committee shall include representatives from the following, as well as any other persons designated by the Secretary of Health and Human Services:

(1) The Department's Division of Medical ~~Assistance, DHHS.~~Assistance.
(2) The Department's Division of Mental Health, Developmental Disabilities, and Substance Abuse ~~Services, DHHS.~~Services.
(3) The Department's Division of Public ~~Health, DHHS.~~Health.
(4) The Rural Health Section of the Department's Division of Public ~~Health, DHHS.~~Health.
(4a) The Division of Adult Correction and Juvenile Justice of the Department of Public Safety.
(5) The State Bureau of Investigation.
(6) The Attorney General's Office.
(7) The following health care regulatory boards with oversight of prescribers and dispensers of prescription drugs:
  a. North Carolina Board of Dental Examiners.
  b. North Carolina Board of Nursing.
  c. North Carolina Board of Podiatry Examiners.
  d. North Carolina Medical Board.
  e. North Carolina Board of Pharmacy.
(8) The UNC Injury Prevention Research Center.
(9) The substance abuse treatment community.
(10) Governor's Institute on Substance Abuse, Inc.
(11) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

(b) In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:

(1) Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.

(2) Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).

(3) Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).

(4) Identify strategic issues based on SWOC and GAP analyses.

(5) Formulate strategies and resources for addressing these issues.

(c) The strategic plan for reducing prescription drug abuse shall include three to five strategic goals that are outcome-oriented and measureable. Each goal must be connected with objectives supported by the following five mechanisms of the system:

(1) Oversight and regulation of prescribers and dispensers by State health care regulatory boards.

(2) Operation of the Controlled Substances Reporting System.

(3) Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.

(4) Enforcement of State laws for the misuse and diversion of controlled substances.

(5) Any other appropriate mechanism identified by the Committee.

(d) ~~DHHS,~~ The Department, in consultation with the Prescription Drug Abuse Advisory Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress toward achieving goals and objectives and must recommend actions to be taken when performance falls short.

(e) Beginning on December 1, 2016, and annually thereafter, DHHS shall submit an annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety."

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

HOUSE BILL 277: Naturopathic Study.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 22, 2017
Introduced by:	Reps. Faircloth, R. Turner, Murphy, Ross	**Prepared by:**	Jason Moran-Bates Committee Co-Counsel
Analysis of:	Amendment to First Edition H277-ASH-20		

OVERVIEW: ***The Amendment H277-ASH-20 to House Bill 277 would create a study group to develop recommendations for the regulation of Naturopathic Medicine in North Carolina.***

CURRENT LAW: Currently, there are no regulations for naturopathic medicine in North Carolina.

BILL ANALYSIS: The Amendment would create a study group develop recommendations for the regulation of Naturopathic Medicine in North Carolina. The study group's recommendations must include:

- Identification of an approved program of study of naturopathic medicine offered by an institution of higher education that leads to a degree as a Doctor of Naturopathic Medicine.
- A scope of practice for naturopathic doctors.
- Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.
- Recommendations on appropriate fees for application, examination, certification, renewals, and late renewals, which may be necessary to cover the costs of oversight.

The group would consist of two Naturopathic Doctors, one medical doctor, the chairperson of the North Carolina Medical Board or the chairperson's designee, and Secretary of the Department of Health and Human Services or the Secretary's designee. The group must meet no later than September 15, 2017, and report its recommendations to the Joint Legislative Oversight Committee on health and Human Services no later than January 31, 2018.

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

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 277
PROPOSED SENATE COMMITTEE SUBSTITUTE H277-PCS30421-SH-28

Short Title: Naturopathic Study. (Public)

Sponsors:

Referred to:

March 8, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A WORK GROUP TO MAKE RECOMMENDATIONS FOR APPROPRIATE OVERSIGHT AND REGULATION OF THE PRACTICE OF NATUROPATHIC MEDICINE IN NORTH CAROLINA AND TO REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Naturopathic medicine is a distinct health care profession that affects the public health, safety, and welfare of the State's residents. Certification of professionals practicing naturopathic medicine will aid in protecting citizens from deception, fraud, and damage to their health status. On or before September 15, 2017, the Secretary of the Department of Health and Human Services, or the Secretary's designee, shall convene a work group to study the delivery of naturopathic medicine in North Carolina. The work group shall be comprised of the following individuals: two naturopathic doctors, selected by the North Carolina Association of Naturopathic Physicians; one medical doctor, who has knowledge of the practice of naturopathic medicine, selected by the North Carolina Medical Society; the chairperson of the North Carolina Medical Board, or the chairperson's designee; and the Secretary of the Department of Health and Human Services, or the Secretary's designee.

SECTION 1.(b) The work group shall develop recommendations necessary to provide appropriate oversight and regulation of naturopathic medicine in the State of North Carolina. The work group's recommendations shall include at least the following:

(1) Identification of an approved program of study of naturopathic medicine that provides graduate-level, full-time didactic and supervised clinical training in naturopathic medicine and is accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession. The program must be offered by an institution of higher education and lead to a degree as a Doctor of Naturopathic Medicine, or equivalent.

(2) A scope of practice for naturopathic doctors, including the extent of their responsibilities as licensed health care professionals; the extent of their ability to diagnose and treat individuals in accordance with the method, thought, and practice of naturopathic medicine and use of diagnostic techniques and therapies; and their prescriptive authority.

(3) Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.

SECTION 1.(c) The work group shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 31, 2018. The report shall include findings and recommendations on the topics outlined in this section and other issues necessary to provide for the appropriate oversight and regulation of the practice of naturopathic medicine in North Carolina. Additionally, the report shall also include recommendations on appropriate fees for application, examination, certification, renewals, and late renewals, as appropriate, to cover the costs associated with oversight.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 277

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

H277-ASH-20 [v.3]

Amends Title [YES]
First Edition

Date 6/22/17 ,2017

Senator Krawiec

moves to amend the bill on page 1, line 1 through page 2, line 37, by rewriting the lines to read:

"A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A WORK GROUP TO MAKE RECOMMENDATIONS FOR APPROPRIATE OVERSIGHT AND REGULATION OF THE PRACTICE OF NATUROPATHIC MEDICINE IN NORTH CAROLINA AND TO REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Naturopathic medicine is a distinct health care profession that affects the public health, safety, and welfare of the State's residents. Certification of professionals practicing naturopathic medicine will aid in protecting citizens from deception, fraud, and damage to their health status. On or before September 15, 2017, the Secretary of the Department of Health and Human Services, or the Secretary's designee, shall convene a work group to study the delivery of naturopathic medicine in North Carolina. The work group shall be comprised of the following individuals: two Naturopathic Doctors, selected by the North Carolina Association of Naturopathic Physicians; one medical doctor, who has knowledge of the practice of naturopathic medicine, selected by the North Carolina Medical Society; the chairperson of the North Carolina Medical Board, or the chairperson's designee; and the Secretary of the Department of Health and Human Services, or the Secretary's designee.

SECTION 1.(b) The work group shall develop recommendations necessary to provide appropriate oversight and regulation of naturopathic medicine in the state of North Carolina. The work group's recommendations shall include at least the following:

(1) Identification of an approved program of study of naturopathic medicine that provides graduate-level, full-time didactic and supervised clinical training in naturopathic medicine and is accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession. The program must be offered by an institution of higher education and lead to a degree as a Doctor of Naturopathic Medicine, or equivalent.

(2) A scope of practice for naturopathic doctors, including the extent of their responsibilities as licensed health care professionals; the extent of their ability to diagnose and

treat individuals in accordance with the method, thought, and practice of naturopathic medicine, and use of diagnostic techniques and therapies; and their prescriptive authority.

(3) Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.

SECTION 1.(c) The work group shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 31, 2018. The report shall include findings and recommendations on the topics outlined in this section and other issues necessary to provide for the appropriate oversight and regulation of the practice of naturopathic medicine in North Carolina. Additionally, the report shall also include recommendations on appropriate fees for application, examination, certification, renewals, and late renewals as appropriate, to cover the costs associated with oversight.

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

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

	M.D. — Medical Doctor	D.O. — Doctor of Osteopathic Medicine	N.D. — Naturopathic Doctor
WHAT SETS THEM APART	A statement from the AMA: "A D.O. (Doctor of Osteopathic Medicine) is a physician just as an M.D. (Doctor of Medicine) is a physician." From the AMA website: "Physicians diagnose and care for people of all ages who are ill or have been injured. They take medical histories, perform physical examinations, conduct diagnostic tests, recommend and provide treatment (including administering pharmaceuticals) and advise patients on their overall health and well-being."	According to Marino, M.D.s and D.O.s have many similarities, and in many cases, especially in hospitals, patients have no idea whether their hospital doctor is an M.D. or D.O. Doctors of osteopathic medicine perform all the tasks as outlined previously for medical doctors. The main difference is that a D.O. takes a holistic approach to treatment, believing that all parts of the body work together and influence one another. They are specially trained in the nervous system and the musculoskeletal system through OMT — using their hands to gently move muscles and joints to diagnose injury and illness and to encourage the body's natural ability to heal. Some traditional osteopaths primarily practice OMT, although their numbers are decreasing.	"We are the most highly trained experts in the field of natural medicine," Skowron says. Although trained in pharmacology, their medicines are vitamins, herbs and homeopathic remedies, but because of their training, naturopaths understand drug interactions. In addition, they diagnose, treat illness and can perform minor surgeries. Like medical doctors and osteopaths, they rely on blood work and tests to make diagnosis. Skowron adds that naturopaths welcome opportunities to work with a patient's medical doctor or osteopath to discover the underlying reasons why someone is not feeling well or living up to their fullest expectations. "We firmly believe that the future of medicine is in integration," Skowron says. There are a few specialties open to naturopaths.
EDUCATION	■ College graduate ■ Requires MCAT (the standardized test that is part of the medical school admissions process) ■ 141 U.S. medical schools* licensed by the Liaison Committee on Medical Education (4 years) ■ Federally mandated residency after medical school, its length dependent on the medical specialty chosen. (Note: the AMA no longer uses the term internship to designate the first year of residency.) ■ Medical doctors can be divided into three broad categories: primary care physicians, surgeons and specialists. ■ Fellowships for additional training are offered. ** Although it's possible to become a U.S. doctor after training in a non-U.S. medical school, the process is quite complicated.*	■ College graduate ■ Requires MCAT ■ 26 U.S. osteopathic medical schools operating in 34 locations licensed by the American Osteopathic Association (4 years) ■ Federally mandated residency after medical school, its length dependent on the medical specialty chosen. D.O.s have a choice between allopathic (M.D.) residencies or osteopathic residencies, accredited by the American Osteopathic Association. ■ D.O.s can be divided into three broad categories: primary care physicians, surgeons and specialists. ■ Fellowships for additional training are offered.	■ College graduates ■ Requires MCAT ■ Five U.S. naturopathic medical schools licensed by the Council on Naturopathic Medical Evaluation (4 years) ■ Residencies are not federally mandated or required in every state except Utah. Only 5 to 10 percent of naturopaths participate in approved residencies, although Skowron says the residency opportunities increase annually, including the Cancer Treatment Centers of America. Instead, new naturopaths either practice or shadow an experienced N.D. before setting up private practice. ■ 1- to 3-year research fellowships are the research equivalent of a residency, according to the Naturopathic Physicians Research Institute. ■ The majority of naturopaths are primary care doctors. The most common specialties are in cancer and pediatrics.
LICENSES AND REQUIREMENTS	■ M.D.s receive their licenses from the New York State Board of Regents: ■ Graduated with the M.D. or D.O. degree from a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association; ■ Completed at least one year of post-graduate medical training as a resident physician in a New York-state approved residency program. ■ Graduates of unaccredited/unregistered medical schools must complete three years of residency and pass a proficiency exam. ■ Successfully passed a State-approved licensing examination. ■ Cost: License, $735. Limited permit: $105.	■ D.O.s receive their licenses from the New York State Board of Regents: ■ Graduated with the M.D. or D.O. degree from a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association; ■ Completed at least one year of post-graduate medical training as a resident physician in a New York-state approved residency program. ■ Graduates of unaccredited/unregistered medical schools must complete three years of residency and pass a proficiency exam. ■ Successfully passed a State-approved licensing examination. ■ Cost: License, $735. Limited permit: $105.	■ N.D.s are not licensed in New York State, although anyone with an N.D. designation is a graduate of a four-year, graduate-level, in-residence naturopathic medical school and maintains a license as a naturopathic physician in at least one of the 14 states that currently licenses naturopathic doctors. There are bills now before the State Senate and the State House calling for N.Y. state licenses for N.D.s. For a list of N.D.s licensed in other states and practicing in New York visit nyanp.org.

SPEAKER SIGN-UP SHEET

Senate Committee Health Care

June 22, 2017 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Meghan Cook	NC Dept. of Insurance

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 22, 2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Carson Buhs	SEANC
Dan Collins	SEANC
Jeff Barnhart	MWC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 22, 2017

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Ken Melton	K. M. A.
Dick Wilkins	Law Office of Dick Wilkins PLLC
Ada Sholar	NCHCFA
[illegible]	SA
Mary Shuping	NCCCS
Lou Turner	SCBH
Sara Beaudoin	SCBH
Ryan Mills	UNC

09-21-201

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Senate Committee on Health Care

June 22, 2017

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L C Revenaugh	CSS
[illegible]	[illegible]
[illegible]	[illegible]
Sara Bell	Burke Tyler
Amy McConkey	NC Beverage Assoc
Phoebe Landon	MWC
[illegible]	IPD
J Peters	CSS
Joyce Pitt	CSC
John Hardy	NTS
Mary Lou	NMRS
Daniel Baum	Tarheel Shredders
Deb Parkerson	Parkerson Law
Jack Lain	[illegible]
Andy Brandon	NCDPS
Karen Brau	NC DPS - Correction Enterprises
Jennifer Mahan	ARNC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 22, 2017

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Clip Baggett	NCMS
Ben Popkin	DHHS
CS Holt	CSA
Peyton Myers	[illegible]
SueAnn Fortis	NCMJ
Evelyn Contre	NC Medical Board
Thom Mansfield	NCMB
Daniel Vanhoose	[illegible]
Cory Hand	NCHA
Tracy Kimbrell	Parker Poe
Doug Heron	Duke
Christine Craig	Wakemed
[illegible]	[illegible]
TJ Bugbee	NP
Skippy	NH
Edward Moore	Troop 137 BSA
Jim Brewer	ASID

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 22, 2017

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NAME	FIRM OR AGENCY AND ADDRESS
Lee Teague	TFG
[illegible]	Dem. Assoc.
Mike McBrady	Biogen
Steve Mitchell	Astellas
[illegible]	NC AFT
Peggy [illegible]	March of Dimes
Tiffany Blakeney	March of Dimes
[illegible]	
[illegible]	
Jeffrey Trendel	NCDOI
Jackie Dausek	NCDOI
Meghan Cook	NCDOI
LT McCrimmon	DHHS
Sarah Wolfe	MWC
Harvey Kaplan	MWC
[illegible]	NCANP
[illegible] Amy Hawkins MD	NCANP

09-21-201

Senate Committee on Health Care
Thursday, June 7, 2018 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 7, 2018 in Room 643 of the Legislative Office Building. The number of members that were present is unknown due to no records being found. These minutes have been created from a recording with no supporting documents by a clerk that did not attend.

Senator Joyce Krawiec, Chair, presided.

Allison Burnett sponsored by Sen. Berger, Ansley McLamb sponsored by Sen. Brown, Morgan Sniffey sponsored by Sen. Randleman, Madison Frazier sponsored by Sen. Randleman, Morgan Moore sponsored by Sen. B. Jackson, Morgan Estes sponsored by Sen. Harrington, Emma Ralling sponsored by Sen. Newton, and Ben Cursetti sponsored by Sen. Berger served as pages.

HB 933 Reciprocity/School Psychologist Licensure. (Representatives Dobson, Torbett, Lewis, Lucas) – FOR DISCUSSION ONLY

Sen. Woodard made the motion for the Proposed Committee Substitute (PCS) to be brought before the committee and the motion carried. Sen. Bullard and Hise were introduced to explain the bill. Questions from the members where answered by Larry Wooten/President of the NC Farm Bureau, Sen. Hise, Rep. Dobson, Jason Bates from the Legislative Analysis Division, and Lynn Macoor/Consultant of School Psychology for DPI. Sen. Krawiec allowed two people to speak from the audience and they were as follows: Joe Wynn from ETNA and Cady Thomas representing the NC Realtors Association.

The meeting adjourned at 10:36.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Health Care
Thursday, June 7, 2018, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 933	Reciprocity/School Psychologist Licensure.	Representative Dobson Representative Torbett Representative Lewis Representative Lucas

FOR DISCUSSION ONLY

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 933
Second Edition Engrossed 5/17/18
PROPOSED SENATE COMMITTEE SUBSTITUTE H933-PCS40765-BC-43

Short Title: Reciprocity/School Psychologist Licensure. (Public)

Sponsors:

Referred to:

May 16, 2018

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO GRANT A LICENSE TO PRACTICE AS A SCHOOL PSYCHOLOGIST TO ANY INDIVIDUALS WHO HOLD THE NATIONALLY CERTIFIED SCHOOL PSYCHOLOGIST CREDENTIAL, ESTABLISHING A PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT), ALLOWING INSURERS TO PROVIDE STOP LOSS INSURANCE TO SMALL BUSINESSES, AND ALLOWING CERTAIN NONPROFIT ORGANIZATIONS TO SPONSOR SELF-FUNDED HEALTH BENEFIT PLANS.

Whereas, school psychologists perform essential services for the social, emotional, and mental health of students throughout North Carolina; and

Whereas, the number of school psychologists in the State has been steadily declining since the 2013-2014 academic year; and

Whereas, one reason the State faces a shortage of school psychologists is the lack of reciprocity granted to individuals who are licensed as school psychologists in other states and may wish to practice in North Carolina; and

Whereas, the standards to receive a Nationally Certified School Psychologist credential from the National Association of School Psychologists are at least as stringent as the standards the State currently requires for licensure as a school psychologist; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 115C-270.20(b) is repealed.

SECTION 1.(b) The catch line of G.S. 115C-270.20 reads as rewritten:

"**§ 115C-270.20. ~~Licensure~~ Teacher licensure requirements.**"

SECTION 2. Article 17E of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-270.21. Administrator and student services personnel licensure requirements.**

(a) Administrators. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for administrators, as provided in this Chapter.

(b) Student Services Personnel. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for student services personnel, as provided in this Article.

The State Board of Education shall issue a school psychologist license to an individual who does any of the following: (i) meets the criteria for licensure as a school psychologist established by the State Board or (ii) holds the Nationally Certified School Psychologist credential issued by the National Association of School Psychologists. For any individual that holds the Nationally Certified School Psychologist credential, a school psychologist license shall be issued to the

individual within 60 days of submission of a completed application that includes documentation verifying that credential."

SECTION 3. Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

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

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance, or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies), to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law

in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI),

or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:
a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;
d. The program must consist of an integrated, organized sequence of study;
e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
f. The designated director of the program must be a psychologist and a member of the core faculty;
g. The program must have an identifiable body of students who are matriculated in that program for a degree;
h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;
(4) No history of adverse action that violates the Rules of the Commission;
(5) No criminal record history that violates the Rules of the Commission;
(6) Possess a current, active IPC;
(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.

(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence.

Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;
(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;
(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;
(9) The Commission shall maintain its financial records in accordance with the Bylaws; and
(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:
(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;
(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;
(3) To purchase and maintain insurance and bonds;
(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;
(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;
(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;
(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;
(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;
(9) To establish a budget and make expenditures;
(10) To borrow money;
(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;
(12) To provide and receive information from, and to cooperate with, law enforcement agencies;
(13) To adopt and use an official seal; and
(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of

psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the

report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors

in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the

Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 5. G.S. 58-50-130 reads as rewritten:

"**§ 58-50-130. Required health care plan provisions.**

(a) Health benefit plans covering small employers are subject to the following provisions:

...

(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than ~~26~~ 16 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:

a. Provides direct coverage of health expenses payable to an individual.

b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

c. Has an annual aggregate attachment point lower than the greater of one of the following:

1. One hundred twenty percent (120%) of expected claims.

2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis.

...."

SECTION 6. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-8. Certain nonprofit health benefit plans not subject to this Chapter.**

(a) A self-funded health benefit plan sponsored by a nonprofit organization that satisfies the conditions of subsection (b) of this section shall be deemed not to be insurance and not subject to this Chapter.

(b) A nonprofit organization that sponsors a self-funded health benefit plan under this section must satisfy all of the following conditions:

(1) Be incorporated in the State.

(2) Have been in existence for 10 continuous years.

(3) Have been determined by the Internal Revenue Service to be a tax exempt organization under Section 501(c) of the Internal Revenue Code.

(4) Provide membership opportunities for eligible individuals or business entities in all 100 counties of the State.

(5) Provide its members with representation on its governing board and committees.

(c) Two or more nonprofit organizations that individually satisfy the conditions of this section may jointly sponsor a health benefit plan for their members.

(d) A nonprofit organization that sponsors a health benefit plan under this section shall file an annual certification with the Secretary of State demonstrating that the organization satisfies the conditions set forth in subsection (b) of this section. A copy of this certification shall be submitted to the Commissioner.

(e) Nothing in this section shall prohibit a person participating in a self-funded health plan under this section from pursuing the remedies set forth in Article 1 of Chapter 75 of the General Statutes."

SECTION 7. Sections 1 and 2 of this act are effective when this act becomes law and apply to applications for licensure submitted on or after that date. Sections 3 and 4 of this act become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in Section 2 of this act. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in Section 4 of this act has been enacted by seven member states. Sections 5 and 6 of this act became effective January 1, 2020.

HOUSE BILL 933:
Reciprocity/School Psychologist Licensure.

2017-2018 General Assembly

Committee:	Senate Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Reps. Dobson, Torbett, Lewis, Lucas	**Prepared by:**	Jason Moran-Bates
Analysis of:	Third Edition		Staff Attorney

OVERVIEW: The proposed committee substitute (PCS) to House Bill 933 would require the State Board of Education to issue a school psychologist license to any individual who holds the Nationally Certified School Psychologist (NCSP) credential issued by the National Association of School Psychologists (NASP) and make some technical changes to the licensing statute for school support personnel. It would make North Carolina a member of the Psychology Interjurisdictional Compact (PSYPACT). Finally, it would change the prohibition on insurers providing stop loss insurance to companies with fewer than 26 employees that do not comply with the provisions of G.S. 58-50-130 to apply to companies with fewer than 10 employees, and it would prevent the regulation under Chapter 58 of self-funded health benefit plans which are sponsored by certain nonprofit organizations.

CURRENT LAW: Under current law, individuals who are already licensed as school psychologists in other states must follow the same process and meet the same criteria as North Carolina residents seeking initial licensure.

Individuals who are licensed as psychologists in other states must pass an examination administered by the North Carolina Psychology Board, apply for a license, pay an application fee, and meet several other requirements before they can be licensed to practice in North Carolina.

Currently insurers may not provide stop loss insurance to employers who employ fewer than 26 individuals unless those employers comply with the provisions of G.S. 58-50-130.

Under current law, self-funded health benefit plans sponsored by nonprofit organizations are subject to regulation under Chapter 58 of the General Statutes.

BILL ANALYSIS:

Sections 1.(a) and 1.(b) of the PCS would make technical changes to G.S. 115C-270.20.

Section 2 of the PCS would require the State Board of Education to issue a school psychologist license to any individual who holds an NCSP credential issued by the NASP.

Section 3 of the PCS would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18G of Chapter 90 of the General Statutes.

Section 4 of the PCS would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

G.S. 09-270.162 would:

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.
    - Investigate complaints against psychologists.
    - Notify the PSYPACT Commission about adverse actions taken against psychologists.
    - Comply with the by-laws of the Commission.
    - Perform criminal background checks on psychologists.
- Allow a psychologist to provide face-to-face services in a compact state if that state:
    - Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
    - Investigates complaints against psychologists.
    - Notifies the PSYPACT Commission about adverse actions taken against psychologists.
    - Complies with the by-laws of the Commission.
    - Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

Section 6 of the PCS would amend G.S. 58-50-130(a)(5) to allow insurers to provide stop loss insurance to employers who have 16 or more employees, even if those employers do not comply with the provisions of G.S. 58-50-130.

Section 7 of the PCS would remove self-funded health benefit plans sponsored by nonprofit organizations from regulation under Chapter 58 of the General Statutes, provided that those nonprofit organizations:

- Are incorporated in North Carolina.
- Have been in existence for at least ten years.

- Are classified as nonprofits under Section 501(c) of the Internal Revenue Code.
- Provide membership opportunities in all 100 counties.
- Provide members with representation on the nonprofit's governing board.

EFFECTIVE DATE:

Sections 1 and 2 of this act are effective when it becomes law and apply to applications for licensure submitted on or after that date.

Sections 3 and 4 of this act become effective when at least seven states have enacted the PSYPACT.

Sections 5 and 6 of this act are effective January 1, 2020.

BACKGROUND:

Sections 1 and 2: These sections were recommended by the House Select Committee on School Safety.

Sections 3 and 4: The PSYPACT is a multi-jurisdictional psychology compact. As of June 6, 2018, it had been enacted by six states (Arizona, Nevada, Utah, Colorado, Nebraska, and Missouri). It has been endorsed by the psychology licensing boards in five states (New Mexico, Texas, Georgia, Ohio, and Wisconsin). PSYPACT legislation is currently being considered in Illinois and Rhode Island. These sections were recommended by the Joint Legislative Oversight Committee on Health and Human Services.

Section 5: Stop loss insurance is a type of insurance designed to limit the exposure of entities that self-insure. The entity typically obtains coverage that will pay all losses in excess of a certain self-insured dollar amount.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

HOUSE BILL 933
Second Edition Engrossed 5/17/18

Short Title:	Reciprocity/School Psychologist Licensure.	(Public)
Sponsors:	Representatives Dobson, Torbett, Lewis, and Lucas (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 16, 2018

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO GRANT A LICENSE TO PRACTICE AS A SCHOOL PSYCHOLOGIST TO ANY INDIVIDUALS WHO HOLD THE NATIONALLY CERTIFIED SCHOOL PSYCHOLOGIST CREDENTIAL, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON SCHOOL SAFETY.

Whereas, school psychologists perform essential services for the social, emotional, and mental health of students throughout North Carolina; and

Whereas, the number of school psychologists in the State has been steadily declining since the 2013-2014 academic year; and

Whereas, one reason the State faces a shortage of school psychologists is the lack of reciprocity granted to individuals who are licensed as school psychologists in other states and may wish to practice in North Carolina; and

Whereas, the standards to receive a Nationally Certified School Psychologist credential from the National Association of School Psychologists are at least as stringent as the standards the State currently requires for licensure as a school psychologist; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 115C-270.20(b) is repealed.

SECTION 1.(b) The catch line of G.S. 115C-270.20 reads as rewritten:

"**§ 115C-270.20. ~~Licensure~~ Teacher licensure requirements.**"

SECTION 2. Article 17E of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-270.21. Administrator and student services personnel licensure requirements.**

(a) Administrators. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for administrators, as provided in this Chapter.

(b) Student Services Personnel. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for student services personnel, as provided in this Article.

The State Board of Education shall issue a school psychologist license to an individual who does any of the following: (i) meets the criteria for licensure as a school psychologist established by the State Board or (ii) holds the Nationally Certified School Psychologist credential issued by the National Association of School Psychologists. For any individual that holds the Nationally Certified School Psychologist credential, a school psychologist license shall be issued to the individual within 60 days of submission of a completed application that includes documentation verifying that credential."

SECTION 3. This act is effective when it becomes law and applies to applications for licensure submitted on or after that date.

Senate Committee on Health Care
Tuesday, June 12, 2018 at 15 minutes after session
Room 544 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 15 minutes after session on June 12, 2018 in Room 544 of the Legislative Office Building. Sixteen members were present.

Sen. Ralph Hise, Chair, presided. There were no pages; Sergeants-at-Arms were recognized, but not named.

Sen. Hise recognized Sen. Krawiec who presented House Bill 512 – Monitor Implementation of TBI Waiver and sent forth an amendment. Sen. Woodard moved for adoption of the amendment; the motion passed. Sen. Tarte moved for a favorable report to the bill as amended, rolled into a PCS unfavorable as to the original bill. The motion passed.

Sen. Hise recognized Sen. Krawiec who presented Senate Bill 750 – Health-Local Confinement/Vet. Controlled Sub and sent forth and explained an amendment. Sen. Krawiec moved for adoption of the amendment; the motion passed. Sen. Harrington moved for a favorable report to the bill as amended, rolled into a PCS unfavorable as to the original bill. The motion passed.

Sen. Hise recognized Sen. Krawiec who presented House Bill 277 – Naturopathic Study and sent forth an amendment, explained the amendment, and moved for adoption of it. The motion passed. Sen. Pate moved for a favorable report to the bill as amended, rolled into a PCS unfavorable as to the original bill.

Sen. Hise passed the gavel to Sen. Pate who presided while Sen. Hise presented House Bill 933 – Reciprocity/School Psychologist Licensure. Sen. Hise sent forth an amendment and explained it. Sen. Bishop moved for adoption of the amendment; the motion passed. After discussion of the amended PCS, Sen. Tarte move for a favorable report to the PCS as amended, unfavorable as to the original bill. The motion passed.

The meeting adjourned at 7:43 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	June 12, 2018	15 minutes after session	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 750	Health-Local Confinement/Vet. Controlled Sub.	Senator Krawiec Senator Pate
HB 277	Naturopathic Study.	Representative Faircloth Representative R. Turner Representative Murphy Representative Ross
HB 933	Reciprocity/School Psychologist Licensure.	Representative Dobson Representative Torbett Representative Lewis Representative Lucas
HB 512	Monitor Implementation of TBI Waiver.	Representative Torbett

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

Senate Committee on Health Care
Tuesday, June 12, 2018, 15 minutes after session
544 Legislative Office Building

AGENDA

Senator Ralph Hise, Presiding

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 750	Health-Local Confinement/Prison HealthConnex.	Senator Krawiec Senator Pate
HB 277	Naturopathic Study.	Representative Faircloth Representative R. Turner Representative Murphy Representative Ross
HB 933	Reciprocity/School Psychologist Licensure.	Representative Dobson Representative Torbett Representative Lewis Representative Lucas
HB 512	Monitor Implementation of TBI Waiver.	Representative Torbett

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Tuesday, June 12, 2018

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

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

SB **750** Health-Local Confinement/Prison HealthConnex.

Draft Number:	S750-PCS45564-BP-9
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

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

HB **512** **(CS#1)** Monitor Implementation of TBI Waiver.

Draft Number:	H512-PCS40761-BCf-42
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

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

HB **277** **(SCS#1)** Naturopathic Study.

Draft Number:	H277-PCS40764-SH-38
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Senator Joyce Krawiec will handle SB 750
Senator Joyce Krawiec will handle HB 512
Senator Joyce Krawiec will handle HB 277

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Hise, Co-Chair
Senator Krawiec, Co-Chair
Senator Pate, Co-Chair

Tuesday, June 12, 2018

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

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

HB **933** Reciprocity/School Psychologist Licensure.

Draft Number:	H933-PCS40765-BC-43
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Ralph Hise will handle HB 933

HOUSE BILL 512:
Monitor Implementation of TBI Waiver.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Rep. Torbett	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	Second Edition		

OVERVIEW: ***House Bill 512 would require the Department of Health and Human Services (Department) to report quarterly on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice; the Joint Legislative Oversight Committee on Health and Human Services; the chairs of the Senate Appropriations Committee on Health and Human Services; the chairs of the House of Representatives Committee on Appropriations, Health and Human Services; and the Fiscal Research Division. The Department is also required to adopt rules or medical coverage policies relating to service programs for individuals with TBI, develop a best practice model and strive to maintain adequate reimbursement rates. The bill would become effective when it becomes law.***

BILL ANALYSIS: House Bill 512 requires the Department of Health and Human Services (Department) to report quarterly on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) to the:

- Joint Legislative Oversight Committee on Medicaid and NC Health Choice;
- Joint Legislative Oversight Committee on Health and Human Services;
- Chairs of the Senate Appropriations Committee on Health and Human Services;
- Chairs of the House of Representatives Committee on Appropriations, Health and Human Services; and the
- Fiscal Research Division.

The Department is also required to do the following three things:

1. Adopt rules or medical coverage policies relating to service programs for individuals with TBI, including setting standards that ensure that individuals with brain injuries who require residential treatment receive appropriate, effective and high-quality treatment in community-based residential settings
2. Develop a best practice model system that includes a comprehensive continuum of care, short-term and long-term treatments, rehabilitation options, and home and community support services.
3. Strive to maintain adequate reimbursement rates for residential and community-based care programs that serve individuals with traumatic brain injury.

EFFECTIVE DATE: House Bill 512 becomes effective when it becomes law.

BACKGROUND: 1915(c) Waivers for Home and Community Based Services allow states to meet the needs of people who prefer to get long-term care services and support in their home or community rather than an institutional setting.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

S.L. 2015-241, Section 12H.6:

TRAUMATIC BRAIN INJURY MEDICAID WAIVER

SECTION 12H.6.(a) The Department of Health and Human Services, Division of Medical Assistance and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department), shall submit to the Centers for Medicare and Medicaid Services a request for approval of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that the Department designed pursuant to Section 12H.6 of S.L. 2014-100, which the Joint Legislative Oversight Committee on Health and Human Services recommended as part of its December 2014 report to the General Assembly, and which is further described in the Department's February 1, 2015, report to the General Assembly.

SECTION 12H.6.(b) The Department shall report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid TBI waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

(1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served.
(2) The expenditures to date and a forecast of future expenditures.
(3) Any recommendations regarding expansion of the waiver.

SECTION 12H.6.(c) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, one million dollars ($1,000,000) for fiscal year 2015-2016 and two million dollars ($2,000.000) for fiscal year 2016-2017 shall be used to fund the Medicaid TBI waiver.

SECTION 12H.6.(d) The waiver and any State Plan amendments required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

The NCGA received an interim report on December 1, 2015 and a final report on March 1, 2016.

Theresa Matula of Legislative Analysis substantially contributed to this summary.

HOUSE BILL 512
Committee Substitute Favorable 4/26/17

Short Title: Monitor Implementation of TBI Waiver. (Public)

Sponsors:

Referred to:

March 29, 2017

A BILL TO BE ENTITLED

AN ACT REGARDING IMPLEMENTATION OF THE 1915(C) MEDICAID WAIVER FOR INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

The General Assembly of North Carolina enacts:

SECTION 1. Beginning October 1, 2017, the Department of Health and Human Services (DHHS) shall report quarterly to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, the chairs of the Senate Appropriations Committee on Health and Human Services, the chairs of the House of Representatives Committee on Appropriations, Health and Human Services, and the Fiscal Research Division on the status and implementation of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that has been submitted to the Centers for Medicare and Medicaid Services in accordance with Section 12H.6 of S.L. 2015-241.

As part of the process of implementing the TBI waiver, DHHS shall adopt rules or medical coverage policies relating to service programs for individuals with traumatic brain injury, including setting standards that ensure that individuals with brain injuries who require residential treatment receive appropriate, effective, and high-quality treatment in community-based residential settings. Additionally, DHHS shall develop a best practice model system that includes a comprehensive continuum of care and an array of short-term and long-term treatments, rehabilitation options, and home and community support services as part of the TBI waiver. Finally, DHHS shall strive to maintain adequate reimbursement rates for residential and community-based care programs that serve individuals with traumatic brain injury, which will aid in attracting and retaining quality and highly specialized providers and programs into North Carolina.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 512

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

H512-ABCf-39 [v.2]

Amends Title [YES]
Second Edition

Date 6/12/ ,2018

Senator KRAWIEC

moves to amend the bill on page 1, line 3, by rewriting the line to read:
"INDIVIDUALS WITH TRAUMATIC BRAIN INJURY; AUTHORIZING TOWNSHIP HOSPITALS STILL OPERATING UNDER PRE 1983 PUBLIC HOSPITAL LAWS TO EXERCISE SOME OF THE ADDITIONAL POWERS AND AUTHORITIES GRANTED TO PUBLIC HOSPITALS OPERATING UNDER ARTICLE 2 OF CHAPTER 131E OF THE GENERAL STATUTES; REDEFINING THE TERM "LEGACY CARE MEDICAL FACILITY" FOR PURPOSES OF CERTIFICATE OF NEED REVIEW; REQUIRING THAT LEGACY MEDICAL CARE FACILITIES EXEMPTED FROM CERTIFICATE OF NEED REVIEW OPERATE WITHIN THE SAME SERVICE AREA AS THE FACILITY THAT CEASED CONTINUOUS OPERATIONS; PROVIDING FOR AN EXTENSION OF THE TIME BY WHICH A FACILITY MUST BE OPERATIONAL IN ORDER TO QUALIFY FOR CERTIFICATE OF NEED EXEMPTION AS A LEGACY MEDICAL CARE FACILITY; AND TO EXEMPT OFFICE BASED, VASCULAR ACCESS CENTERS FROM CERTIFICATE OF NEED REVIEW.";

and on page 1, line 5, by deleting "2017," and replacing it with "2018,";

and on page 1, line 25, by rewriting the line to read:

"**SECTION 2.(a)** All hospitals that continue to operate under Article 2 of Chapter 131 of the General Statutes pursuant to Section 3 of Chapter 775 of the 1983 Session Laws may, in addition to the powers and authorities set forth in said Article 2 of Chapter 131 of the General Statutes, exercise each of the powers, authorities, and exemptions set forth in the following provisions of Chapter 131E of the General Statutes, singly or in combination:

(1) G.S. 131E-7(a)(1), (3), (5), and (6).
(2) G.S. 131E-7(b).
(3) G.S. 131E-7(c).
(4) G.S. 131E-7(f).
(5) G.S. 131E-7.1.
(6) G.S. 131E-8.
(7) G.S. 131E-10.
(8) G.S. 131E-11.
(9) G.S. 131E-13.

(10) G.S. 131E-14.1.
(11) G.S. 131E-23(a)(1) through (38).
(12) G.S. 131E-23(b).
(13) G.S. 131E-23(d).
(14) G.S. 131E-26.
(15) G.S. 131E-27.
(16) G.S. 131E-32.
(17) G.S. 131E-47.1.

SECTION 2.(b) This act amends and adds to the powers and authorities previously conveyed by Section 3 of S.L. 1999-377 to hospitals that continue to operate under Article 2 of Chapter 131 of the General Statutes. This act is not intended to alter or amend the remaining provisions of S.L. 1999-377.

SECTION 3.(a) G.S. 131E-176(14f) reads as rewritten:

"(14f) "Legacy Medical Care Facility" means ~~an institutiona~~ facility that meets all of the following requirements:

a. Is not presently operating.
b. Has not continuously operated for at least the past six months.
c. Within the last 24 months:
1. Was operated by a person holding a license under G.S. 131E-77; and
2. Was primarily engaged in providing to ~~inpatients.~~inpatients or outpatients, by or under supervision of physicians. (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

SECTION 3.(b) G.S. 131E-184(h) reads as rewritten:

"(h) The Department shall exempt from certificate of need review the acquisition or reopening of a Legacy Medical Care Facility. The person seeking to operate a Legacy Medical Care Facility ~~must~~ shall give the Department written notice ~~(i) of its~~of all of the following:

(1) Its intention to acquire or reopen a Legacy Medical Care Facility within the same county and the same service area as the facility that ceased continuous operations. If the Legacy Medical Facility will become operational in a new location within the same county and the same service area as the facility that ceased continuous operations, then the person responsible for giving the written notice required by this section shall notify the Department, as soon as reasonably practicable and prior to becoming operational, of the new location of the Legacy Medical Care Facility. For purposes of this subdivision, "service area" means the service area identified in the North Carolina State Medical Facilities Plan in effect at the time the written notice required by this section is given to the Department.
(2) ~~and (ii) that~~That the ~~hospital~~ facility will be operational within 36 months of the notice.

The Department shall extend the time by which a facility must be operational in order to be exempt from certificate of need review under this subsection by one additional 36-month period if the person seeking to reopen or acquire the Legacy Medical Care Facility gives the Department written notice of extension within 36 months of the original notice of intent to acquire or reopen the Legacy Medical Care Facility. The written notice of extension must notify the Department (i) that the person has undertaken all reasonable efforts to make the facility operational within 36 months of the notice of intent, (ii) that, despite these reasonable efforts, the person does not anticipate the facility will be operational within that time, and (iii) of its intention that the facility will be operational within 36 months of the notice of extension."

SECTION 4.(a) G.S. 131E-175 reads as rewritten:

"Article 9.
Certificate of Need.

"§ 131E-175. Findings of fact.

The General Assembly of North Carolina makes the following findings:

...

(13) That physicians providing care for vascular access sites in unlicensed settings should be given an opportunity to obtain a license to provide those services to ensure the safety of patients and the provision of quality care.

(14) That demand for establishing and maintaining vascular access sites, which is often an emergency surgical procedure, is increasing at a fast rate as more North Carolinians are living longer with end stage renal disease.

(15) That continuing to treat vulnerable patients with end stage renal disease outside of the hospital lowers costs, reduces overnight hospital stays, and keeps patients healthier."

SECTION 4.(b) G.S. 131E-178 reads as rewritten:

"§ 131E-178. Activities requiring certificate of need.

...

(a1) No person shall offer or develop a new institutional health service without first obtaining a certificate of need from the Department; provided, however, no person who provides vascular access for hemodialysis in a physician office based vascular access center located in a nonlicensed setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of vascular access procedure rooms, provided that:

(1) The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2018.

(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act.

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of

Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department.

(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.

All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of vascular access site management shall be required to obtain a certificate of need.

..."

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

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 512:
Amendment H512-ABCf-39

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Rep. Torbett	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	Amendment to Second Edition H512-ABCf-39		

OVERVIEW: ***Amendment H512-ABCf-39 would allow township hospitals that continue to operate under Article 2 of Chapter 131 of the General Statutes, pursuant to Section 3 of Chapter 775 of the 1983 Session Laws to exercise many of the powers currently permitted to public hospitals under Article 2 of Chapter 131E of the General Statutes. It would also amend G.S. 131E-184(h) to extend the period in which the acquisition or reopening of a Legacy Medical Facility is exempt from Certificate of Need review by 36 months. In addition, it would change the definition of "Legacy Medical Facility" to include facilities that provided outpatient care. Finally, it would exempt individuals who provide vascular access for hemodislysis in a physician office based vascular service center from Certificate of Need review.***

CURRENT LAW: Currently township hospitals operate under Article 2 of Chapter 131of the General Statutes as it existed in 1983. They lack the statutory authority to exercise many of the powers granted to public hospitals under Article 2 of Chapter 131E of the General Statutes. In order to be exempt from Certificate of Need review, a Legacy Medical Facility must be operational within 36 months of the date it gives notice it is to reopen or be acquired, and the original facility on which the Legacy Medical Facility is based must have provided only inpatient care.

BILL ANALYSIS:

Section 2 of the Amendment would grant township hospitals the power to:

- Construct hospital facilities and issue bonds and acquire real property for the purpose of constructing hospital facilities.
- Enter into contracts and agreements with other hospitals or municipalities.
- Acquire an ownership stake in a managed care company.
- Sell rights in the hospital facility to a non-profit corporation.
- Accept federal and State money.
- Lease or sell hospital facilities to any corporation, subject to certain regulations.
- Build branches outside their home counties, subject to certain regulations.
- Exercise power through an agent.

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- Not be subject to regulations on the disposal of property by public bodies unless the General Assembly enacts specific legislation making those regulations apply.
- Take out a mortgage to acquire property.
- Exercise all the corporate powers necessary to operate a hospital.

Section 3 of the Amendment would amend G.S. 131E-184(h) to grant Legacy Medical Facilities an additional 36 months to become operational and still be exempt from Certificate of Need review. It would also require the person responsible for giving notice to notify the Department of Health and Human Services if the Legacy Medical Facility were going to open in a new location in the same county as the facility that ceased operations. Finally, it would modify the definition of "Legacy Medical Facility" to include facilities that mainly provided outpatient care.

Section 4 of the Amendment would exempt individuals who provide vascular access for hemodislysis in a physician office based vascular service center from Certificate of Need review, so long as they:

- Applied for a licensed before December 31, 2018.
- Certify the facility will be operational within 60 days of the effective date of this act.
- Have been accredited by a recognized ambulatory healthcare accrediting agency.
- Have a plan for serving indigent and medically underserved populations.

EFFECTIVE DATE: The amended sections would be effective when they become law.

BACKGROUND: A "Legacy Medical Facility" is a healthcare facility that (1) is not currently operating, (2) has not operated in the last six months, and (3) within the last two years held a hospital license while providing inpatient care.

SENATE BILL 750: Health-Local Confinement/Prison HealthConnex.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 11, 2018
Introduced by:	Sens. Krawiec, Pate	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	First Edition		

OVERVIEW: Senate Bill 750 requires immediate notification of the medical examiner and the coroner immediately when a prisoner in the custody of a local confinement facility dies, regardless of the physical location of the prisoner at the time of death; the Department of Health and Human Services (DHHS) to study how to improve prisoner health screening with a goal of improving the administration of life-saving prescription medications; requires DHHS and the Government Data Analytics Center (GDAC) in the Department of Information Technology to explore local confinement facility participation in NC HealthConnex; requires the Department of Public Safety, DHHS, and GDAC to ensure prison facilities are full participants in NC HealthConnex; and requires reports on the studies contained in the bill to the Joint Legislative Oversight Committee on Health and Human Services.

This bill was a recommendation from the Joint Legislative Oversight Committee on Health and Human Services.

[As introduced, this bill was identical to H1045, as introduced by Reps. Dobson, Lambeth, R. Turner, which is currently in House Health.]

BILL ANALYSIS:

Section 1 of SB 750 amends G.S. 153A-225 pertaining to the medical care of prisoners in local confinement facilities. G.S. 153A-217(5) defines a local confinement facility as including a county or city jail, a local lockup, a regional or district jail, a juvenile detention facility, a detention facility for adults operated by a local government, and any other facility operated by a local government for confinement of persons awaiting trial or serving sentences except that it shall not include a county satellite jail/work release unit governed by Part 3 of Article 10 of Chapter 153A. The bill specifically amends G.S. 153A-225(b) to require that the medical examiner and the coroner must be notified immediately if a prisoner in the custody of a local confinement facility dies, regardless of the physical location of the prisoner at the time of death.

Section 2 requires the Department of Health and Human Services (DHHS) to study how to improve prisoner health screening with a goal of improving the determination that a prisoner in a local confinement facility has been prescribed life-saving prescription medications and a process to ensure the timely administration of those prescription medications. DHHS is required to report on or before November 1, 2018 to the Joint Legislative Oversight Committee on Health and Human Services (JLOCHHS).

Section 3(a) requires the Department of Public Safety, DHHS, and the Government Data Analytics Center (GDAC) within the Department of Information Technology (DIT) to work collaboratively with organizations representing local government and law enforcement to facilitate the secure transmission of health information pertaining to prisoners in local confinement facilities through participation in the NC Health Information Exchange Network (HIE Network), known as NC HealthConnex. **Section 3(b)**

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requires the Department of Public Safety, DHHS, and GDAC to ensure prison facilities are full participants in NC HealthConnex. **Section 3(c)** requires DHHS and GDAC, to provide an interim report to JLOCHHS on or before October 1, 2018 and a final report on or before October 1, 2019.

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

SENATE BILL 750*

Short Title:	Health-Local Confinement/Prison HealthConnex.	(Public)
Sponsors:	Senators Krawiec and Pate (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

May 29, 2018

A BILL TO BE ENTITLED

AN ACT TO ADDRESS HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES AND TO ENSURE THAT STATE PRISONS ARE FULL PARTICIPANTS IN THE NC HEALTH INFORMATION EXCHANGE KNOWN AS NC HEALTHCONNEX, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 153A-225 reads as rewritten:

"**§ 153A-225. Medical care of prisoners.**

(a) Each unit that operates a local confinement facility shall develop a plan for providing medical care for prisoners in the facility. The plan:

(1) Shall be designed to protect the health and welfare of the prisoners and to avoid the spread of contagious disease;

(2) Shall provide for medical supervision of prisoners and emergency medical care for prisoners to the extent necessary for their health and welfare;

(3) Shall provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal diseases; and

(4) May utilize Medicaid coverage for inpatient hospitalization or for any other Medicaid services allowable for eligible prisoners, provided that the plan includes a reimbursement process which pays to the State the State portion of the costs, including the costs of the services provided and any administrative costs directly related to the services to be reimbursed, to the State's Medicaid program.

The unit shall develop the plan in consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society. The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners. Upon a determination that the plan is adequate to protect the health and welfare of the prisoners, the plan must be adopted by the governing body.

As a part of its plan, each unit may establish fees of not more than twenty dollars ($20.00) per incident for the provision of nonemergency medical care to prisoners and a fee of not more than ten dollars ($10.00) for a 30-day supply or less of a prescription drug. In establishing fees pursuant to this section, each unit shall establish a procedure for waiving fees for indigent prisoners.

(b) If a prisoner in the custody of a local confinement facility dies, the medical examiner and the coroner shall be notified ~~immediately.~~ immediately, regardless of the physical location of the prisoner at the time of death. Within five days after the day of the death, the administrator of the facility shall make a written report to the local or district health director and to the Secretary of Health and Human Services. The report shall be made on forms developed and distributed by the Department of Health and Human Services.

(b1) Whenever a local confinement facility transfers a prisoner from that facility to another local confinement facility, the transferring facility shall provide the receiving facility with any health information or medical records the transferring facility has in its possession pertaining to the transferred prisoner.

(c) If a person violates any provision of this section (including the requirements regarding G.S. 130-97 and 130-121), he is guilty of a Class 1 misdemeanor."

SECTION 2. Consistent with the requirements of G.S. 153A-216(3) and G.S. 153A-221, the Department of Health and Human Services shall study how to improve prisoner health screening with a goal of improving the determination that a prisoner in a local confinement facility has been prescribed life-saving prescription medications and a process to ensure the timely administration of those prescription medications by appropriate personnel. On or before November 1, 2018, the Department shall provide a report on this study to the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 3.(a) The Department of Health and Human Services and the Government Data Analytics Center within the Department of Information Technology shall jointly collaborate with organizations representing local government and local law enforcement to explore participation by local confinement facilities in the North Carolina Health Information Exchange Network (HIE Network), known as NC HealthConnex, in order to facilitate the secure electronic transmission of individually identifiable health information pertaining to prisoners in the custody of local confinement facilities.

SECTION 3.(b) The Department of Public Safety, the Department of Health and Human Services, and the Government Data Analytics Center within the Department of Information Technology, shall work collaboratively to ensure North Carolina prison facilities are full participants in the HIE Network, known as NC HealthConnex, in order to facilitate the secure electronic transmission of individually identifiable health information pertaining to inmates in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.

SECTION 3.(c) On or before October 1, 2018, the Department of Health and Human Services and the Government Data Analytics Center within the Department of Information Technology, shall provide an interim report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section. On or before October 1, 2019, the Department of Health and Human Services and the Government Data Analytics Center within the Department of Information Technology, shall provide a final report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 750*

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

S750-ABP-2 [v.2]

Amends Title [YES]
First Edition

Date 6/12 ,2018

Senator Krawiec

moves to amend the bill on page 1, line 6, by rewriting the line to read:
"HEALTH AND HUMAN SERVICES; AND TO AMEND THE NORTH CAROLINA CONTROLLED SUBSTANCES ACT AND THE CONTROLLED SUBSTANCES REPORTING SYSTEM PERTAINING TO THE PRACTICE OF VETERINARY MEDICINE; TO REQUIRE CONTINUING EDUCATION FOR VETERINARIANS ON ABUSE OF CONTROLLED SUBSTANCES; AND TO INCLUDE THE NORTH CAROLINA VETERINARY MEDICAL BOARD ON THE PRESCRIPTION DRUG ABUSE ADVISORY COMMITTEE.";

and on page 2, line 41, by rewriting the line to read:

"**SECTION 4.** G.S. 90-113.74C reads as rewritten:

"**§ 90-113.74C. Practitioner use of controlled substances reporting system; mandatory reporting of violations.**

(a) Prior to initially prescribing a targeted controlled substance to a patient, a practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription. For every subsequent three-month period that the targeted controlled substance remains a part of the patient's medical care, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the determination that the targeted controlled substance should remain a part of the patient's medical care. Each instance in which the practitioner reviews the information in the controlled substances reporting system pertaining to the patient shall be documented in the patient's medical record. In the event the practitioner is unable to review the information in the controlled substances reporting system pertaining to the patient because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the patient's medical record. Once the electrical or technological failure has been resolved, the practitioner shall review the information in the controlled substances reporting system pertaining to the patient and the review shall be documented in the patient's medical record.

(b) A practitioner may, but is not required to, review the information in the controlled substances reporting system pertaining to a patient prior to prescribing a targeted controlled substance to the patient in any of the following circumstances:

(1) The controlled substance is to be administered to a patient in a health care setting, hospital, nursing home, outpatient dialysis facility, or residential care facility, as defined in G.S. 14-32.2.

(2) The controlled substance is prescribed for the treatment of cancer or another condition associated with cancer.

(3) The controlled substance is prescribed to a patient in hospice care or palliative care.

(c) The Department shall conduct periodic audits of the review of the controlled substances reporting system by prescribers. The Department shall determine a system for selecting a subset of prescriptions to examine during each auditing period. The Department shall report to the appropriate licensing board any prescriber found to be in violation of this section. A violation of this section may constitute cause for the licensing board to suspend or revoke a prescriber's license.

(d) For purposes of this section, a "practitioner" does not include a person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes."

SECTION 5. G.S. 90-106(a1) reads as rewritten:

"(a1) Electronic Prescription Required; Exceptions. – Unless otherwise exempted by this subsection, a practitioner shall electronically prescribe all targeted controlled substances. This subsection does not apply to prescriptions for targeted controlled substances issued by any of the following:

(1) A practitioner, other than a pharmacist, who dispenses directly to an ultimate user.

(2) A practitioner who orders a controlled substance to be administered in a hospital, nursing home, hospice facility, outpatient dialysis facility, or residential care facility, as defined in G.S. 14-32.2.

(3) A practitioner who experiences temporary technological or electrical failure or other extenuating circumstance that prevents the prescription from being transmitted electronically; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(4) A practitioner who writes a prescription to be dispensed by a pharmacy located on federal property; provided, however, that the practitioner documents the reason for this exception in the patient's medical record.

(5) A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes may continue to prescribe targeted controlled substances from valid written, oral or facsimile prescriptions that are otherwise consistent with applicable laws."

SECTION 6. G.S. 90-113.73 reads as rewritten:

"**§ 90-113.73. Requirements for controlled substances reporting system; civil penalties for failure to properly report.**

(a) The Department shall establish and maintain a reporting system of prescriptions for all Schedule II through V controlled substances. Each dispenser shall submit the information in accordance with transmission methods and frequency established by rule by the Commission.

The Department may issue a waiver to a dispenser who is unable to submit prescription information by electronic means. The waiver may permit the dispenser to submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. The dispenser shall report the information required under this section no later than the close of the next business day after the prescription is delivered; however, dispensers are encouraged to report the information no later than 24 hours after the prescription was delivered. The information shall be submitted in a format as determined annually by the Department based on the format used in the majority of the states operating a controlled substances reporting system. In the event the dispenser is unable to report the information within the time frame required by this section because the system is not operational or there is some other temporary electrical or technological failure, this inability shall be documented in the dispenser's records. Once the electrical or technological failure has been resolved, the dispenser shall promptly report the information.

(b) The Commission shall adopt rules requiring dispensers to report the following information. The Commission may modify these requirements as necessary to carry out the purposes of this Article. The dispenser shall report:

(1) The dispenser's DEA number.
(2) The name of the patient for whom the controlled substance is being dispensed, and the patient's:
  a. Full address, including city, state, and zip code,
  b. Telephone number, and
  c. Date of birth.
(3) The date the prescription was written.
(4) The date the prescription was filled.
(5) The prescription number.
(6) Whether the prescription is new or a refill.
(7) Metric quantity of the dispensed drug.
(8) Estimated days of supply of dispensed drug, if provided to the dispenser.
(9) National Drug Code of dispensed drug.
(10) Prescriber's DEA number.
(11) Method of payment for the prescription.

(c) A dispenser shall not be required to report instances in which a controlled substance is provided directly to the ultimate user and the quantity provided does not exceed a 48-hour supply.

(d) A dispenser shall not be required to report instances in which a Schedule V non-narcotic, non-anorectic Schedule V controlled substance is provided directly to the ultimate user for the purpose of assessing a therapeutic response when prescribed according to indications approved by the United States Food and Drug Administration.

(e) The Department shall assess, against any pharmacy that employs dispensers found to have failed to report information in the manner required by this section within a reasonable period of time after being informed by the Department that the required information is missing or incomplete, a civil penalty of not more than one hundred dollars ($100.00) for a first violation, two hundred fifty dollars ($250.00) for a second violation, and five hundred dollars ($500.00)

for each subsequent violation if the pharmacy fails to report as required under this section, up to a maximum of five thousand dollars ($5,000) per pharmacy per calendar year. Each day of a continuing violation shall constitute a separate violation. A pharmacy acting in good faith that attempts to report the information required by this section shall not be assessed any civil penalty. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes. The Commission shall adopt rules to implement this subsection that include factors to be considered in determining the amount of the penalty to be assessed.

(f) For purposes of this section, a "dispenser" includes a person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes when that person dispenses any Schedule II through V controlled substances. A person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes may submit prescription information by paper form or other means, provided all information required of electronically submitted data is submitted. Notwithstanding subsection (b) of this section, the Commission shall adopt rules requiring the information to be reported by a person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes."

SECTION 7. G.S. 90-106 reads as rewritten:

"**§ 90-106. Prescriptions and labeling.**

...

(a3) Limitation on Prescriptions Upon Initial Consultation for Acute Pain. – A practitioner may not prescribe more than a five-day supply of any targeted controlled substance upon the initial consultation and treatment of a patient for acute pain, unless the prescription is for post-operative acute pain relief for use immediately following a surgical procedure. A practitioner shall not prescribe more than a seven-day supply of any targeted controlled substance for post-operative acute pain relief immediately following a surgical procedure. Upon any subsequent consultation for the same pain, the practitioner may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance. This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in a hospital, nursing home licensed under Chapter 131E of the General Statutes, hospice facility, or residential care facility, as defined in G.S. 14-32.2(c1). This subsection does not apply to prescriptions for controlled substances issued by a practitioner who orders a controlled substance to be wholly administered in an emergency facility, veterinary hospital or animal hospital, as defined in G.S. 90-181.1. A practitioner who acts in accordance with the limitation on prescriptions as set forth in this subsection shall be immune from any civil liability or disciplinary action from the practitioner's occupational licensing agency for acting in accordance with this subsection.

(a4) Definitions. – As used in this subsection, the following terms have the following meanings:

(1) Acute pain. – Pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. The term does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder. The term does not include pain being

treated as part of cancer care, hospice care or palliative care provided by a person licensed to practice veterinary medicine pursuant to Article 11 of Chapter 90 of the General Statutes.

(2) Chronic pain. – Pain that typically lasts for longer than three months or that lasts beyond the time of normal tissue healing.

(3) Surgical procedure. – A procedure that is performed for the purpose of structurally altering the human body by incision or destruction of tissues as part of the practice of ~~medicine.~~medicine or a procedure that is performed for the purpose of structurally altering the animal body by incision or destruction of tissues as part of the practice of veterinary medicine. This term includes the diagnostic or therapeutic treatment of conditions or disease processes by use of instruments such as lasers, ultrasound, ionizing, radiation, scalpels, probes, or needles that cause localized alteration or transportation of live human ~~tissue~~tissue, or live animal tissue in the practice of veterinary medicine, by cutting, burning, vaporizing, freezing, suturing, probing, or manipulating by closed reduction for major dislocations and fractures, or otherwise altering by any mechanical, thermal, light-based, electromagnetic, or chemical means.

...."

SECTION 8. Section 12F.16.(b) of Session Law 2015-241 reads as rewritten:

"**SECTION 12F.16.(b)** The following health care provider occupational licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

(1) North Carolina Board of Dental Examiners.
(2) North Carolina Board of Nursing.
(3) North Carolina Board of Podiatry Examiners.
(4) North Carolina Medical Board.
(5) North Carolina Veterinary Medical Board."

SECTION 9. Section 12F.16.(m) of S.L. 2015-241, as amended by Section 4.5 of S.L. 2015-268, reads as rewritten:

"**SECTION 12F.16.(m)** There is hereby created the Prescription Drug Abuse Advisory Committee, to be housed in and staffed by the Department of Health and Human Services (DHHS). The Committee shall develop and, through its members, implement a statewide strategic plan to combat the problem of prescription drug abuse. The Committee shall include representatives from the following, as well as any other persons designated by the Secretary of Health and Human Services:

(1) The Division of Medical Assistance, DHHS.
(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.
(3) The Division of Public Health, DHHS.
(4) The Office of Rural Health, DHHS.
(5) The State Bureau of Investigation.
(6) The Attorney General's Office.

(7) The following health care regulatory boards with oversight of prescribers and dispensers of prescription drugs:
  a. North Carolina Board of Dental Examiners.
  b. North Carolina Board of Nursing.
  c. North Carolina Board of Podiatry Examiners.
  d. North Carolina Medical Board.
  e. North Carolina Board of Pharmacy.
  f. North Carolina Veterinary Medical Board.
(8) The UNC Injury Prevention Research Center.
(9) The substance abuse treatment community.
(10) Governor's Institute on Substance Abuse, Inc.
(11) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina."

SECTION 10. Section 5 of this act becomes effective January 1, 2020. Section 8 of this act become effective when it becomes law and shall apply to renewal applications received in 2020. The remainder of this Act shall become effective when it becomes law.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

AMENDMENT: S750-ABP-2
Amend Cont. Sub. Act/Veterinarians.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Sens. Krawiec, Pate	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	Amendment to First Edition S750-ABP-2		

OVERVIEW: ***The amendment (S750-ABP-2) for Senate Bill 750 amends the North Carolina Controlled Substance Act and the Controlled Substances Reporting System (CSRS) pertaining to the practice of veterinary medicine; requires continuing education for veterinarians on controlled substance abuse; and includes the North Carolina Veterinary Medical Board (Veterinary Medical Board) on the Prescription Drug Abuse Advisory Committee.***

BILL ANALYSIS:

Amendment S750-ABP-2 amends Senate Bill 750 by adding the following:

Section 4 clarifies a practitioner does not include a veterinarian for purposes of this section, which exempts a veterinarian from having to review patient information in the CSRS prior to prescribing a targeted controlled substance.

Section 5 states a veterinarian may continue to prescribe targeted controlled substances from valid written, oral or facsimile prescriptions. This further clarifies the exemption for a veterinarian from the electronic prescription requirement. The existing statute and this clarification are not effective until January 1, 2020. Under current law, a dispenser who dispenses any Schedule II to V Controlled Substance must report prescription information to the CSRS. **Section 6** clarifies a dispenser includes a veterinarian for purposes of this section.

Under current law a practitioner may not prescribe more than a five day supply of any targeted controlled substance upon initial consultation and treatment of a patient for acute pain or prescribe more than a seven day supply of any targeted controlled substance for post-operative acute pain following a surgical procedure. **Section 7** exempts prescriptions for controlled substances wholly administered in an emergency facility, veterinary hospital or animal hospital as defined in G.S. 90-181.1, from the five day and seven day limitations on prescriptions for acute pain. Section 7 clarifies the definition of acute pain does not include pain treated as part of cancer care, hospice care or palliative care provided by a veterinarian. Section 7 modifies the definition of surgical procedure to include procedures performed by a veterinarian.

Section 8 requires the Veterinary Medical Board to require continuing education on the abuse of controlled substances as a condition of license renewal.

Section 9 adds the Veterinary Medical Board to the Prescription Drug Abuse Advisory Committee.

EFFECTIVE DATE: Section 5 of the amendment becomes effective January 1, 2020. Section 8 of the amendment becomes effective when it becomes law and shall apply to renewal applications received in 2020. The remainder of the amendment becomes effective when it becomes law.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 277: Naturopathic Study.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Reps. Faircloth, R. Turner, Murphy, Ross	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	Second Edition		

OVERVIEW: House Bill 277 creates a study of naturopathic medicine.

BILL ANALYSIS: House Bill 277 creates a study group to develop recommendations for the regulation of naturopathic medicine in North Carolina. The Secretary of the Department of Health and Human Services (DHHS) or the Secretary's designee is required to convene a work group to study the delivery of naturopathic medicine in North Carolina. The group would consist of:

- two naturopathic doctors,
- one medical doctor,
- the chairperson of the North Carolina Medical Board or the chairperson's designee,
- the Secretary of DHHS or the Secretary's designee

The study group's recommendations must include the following:

- Identification of an approved program of study of naturopathic medicine offered by an institution of higher education that leads to a degree as a Doctor of Naturopathic Medicine.
- A scope of practice for naturopathic doctors.
- Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.
- Recommendations on appropriate fees for application, examination, certification, renewals, and late renewals, which may be necessary to cover the costs of oversight.

The work group is required to report its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services. The recommendations must include appropriate fees for application, examination, certification, renewals, and late renewal, as appropriate to cover the associated costs for oversight.

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

Karen Cochrane-Brown
Director

H277-SMSH-105 E2 -V-2

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 277
Senate Health Care Committee Substitute Adopted 6/22/17

Short Title: Naturopathic Study. (Public)

Sponsors:

Referred to:

March 8, 2017

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A WORK GROUP TO MAKE RECOMMENDATIONS FOR APPROPRIATE OVERSIGHT AND REGULATION OF THE PRACTICE OF NATUROPATHIC MEDICINE IN NORTH CAROLINA AND TO REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Naturopathic medicine is a distinct health care profession that affects the public health, safety, and welfare of the State's residents. Certification of professionals practicing naturopathic medicine will aid in protecting citizens from deception, fraud, and damage to their health status. On or before September 15, 2017, the Secretary of the Department of Health and Human Services, or the Secretary's designee, shall convene a work group to study the delivery of naturopathic medicine in North Carolina. The work group shall be comprised of the following individuals: two naturopathic doctors, selected by the North Carolina Association of Naturopathic Physicians; one medical doctor, who has knowledge of the practice of naturopathic medicine, selected by the North Carolina Medical Society; the chairperson of the North Carolina Medical Board, or the chairperson's designee; and the Secretary of the Department of Health and Human Services, or the Secretary's designee.

SECTION 1.(b) The work group shall develop recommendations necessary to provide appropriate oversight and regulation of naturopathic medicine in the State of North Carolina. The work group's recommendations shall include at least the following:

(1) Identification of an approved program of study of naturopathic medicine that provides graduate-level, full-time didactic and supervised clinical training in naturopathic medicine and is accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession. The program must be offered by an institution of higher education and lead to a degree as a Doctor of Naturopathic Medicine, or equivalent.

(2) A scope of practice for naturopathic doctors, including the extent of their responsibilities as licensed health care professionals; the extent of their ability to diagnose and treat individuals in accordance with the method, thought, and practice of naturopathic medicine and use of diagnostic techniques and therapies; and their prescriptive authority.

(3) Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.

SECTION 1.(c) The work group shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 31, 2018. The report shall include findings and recommendations on the topics outlined in this section and other issues necessary to provide for the appropriate oversight and regulation of the practice of naturopathic medicine in North Carolina. Additionally, the report shall also include recommendations on appropriate fees for application, examination, certification, renewals, and late renewals, as appropriate, to cover the costs associated with oversight.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 277

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

H277-ASH-43 [v.1]

Amends Title [NO]
Second Edition

Date 6-12, 2018

Senator Krawiec

moves to amend the bill on page 1, line 11, by rewriting the line to read:

"fraud, damage to their health status. On or before September 15, 2018, the Secretary of the";

and to amend page 2, lines 2-3, by rewriting the lines to read:

"Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2019. The report shall include findings and recommendations on the topics outlined in this"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

HOUSE BILL 933:
Reciprocity/School Psychologist Licensure.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 6, 2018
Introduced by:	Reps. Dobson, Torbett, Lewis, Lucas	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to Second Edition H933-CSBC-40		

OVERVIEW: ***The proposed committee substitute (PCS) to House Bill 933 would require the State Board of Education to issue a school psychologist license to any individual who holds the Nationally Certified School Psychologist (NCSP) credential issued by the National Association of School Psychologists (NASP) and make some technical changes to the licensing statute for school support personnel. It would make North Carolina a member of the Psychology Interjurisdictional Compact (PSYPACT). Finally, it would change the prohibition on insurers providing stop loss insurance to companies with fewer than 26 employees that do not comply with the provisions of G.S. 58-50-130 to apply to companies with fewer than 10 employees, and it would prevent the regulation under Chapter 58 of self-funded health benefit plans which are sponsored by certain nonprofit organizations.***

CURRENT LAW: Under current law, individuals who are already licensed as school psychologists in other states must follow the same process and meet the same criteria as North Carolina residents seeking initial licensure.

Individuals who are licensed as psychologists in other states must pass an examination administered by the North Carolina Psychology Board, apply for a license, pay an application fee, and meet several other requirements before they can be licensed to practice in North Carolina.

Currently insurers may not provide stop loss insurance to employers who employ fewer than 26 individuals unless those employers comply with the provisions of G.S. 58-50-130.

Under current law, self-funded health benefit plans sponsored by nonprofit organizations are subject to regulation under Chapter 58 of the General Statutes.

BILL ANALYSIS:

Sections 1.(a) and 1.(b) of the PCS would make technical changes to G.S. 115C-270.20.

Section 2 of the PCS would require the State Board of Education to issue a school psychologist license to any individual who holds an NCSP credential issued by the NASP.

Section 3 of the PCS would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18G of Chapter 90 of the General Statutes.

Section 4 of the PCS would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

G.S. 09-270.162 would:

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.
    - Investigate complaints against psychologists.
    - Notify the PSYPACT Commission about adverse actions taken against psychologists.
    - Comply with the by-laws of the Commission.
    - Perform criminal background checks on psychologists.
- Allow a psychologist to provide face-to-face services in a compact state if that state:
    - Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
    - Investigates complaints against psychologists.
    - Notifies the PSYPACT Commission about adverse actions taken against psychologists.
    - Complies with the by-laws of the Commission.
    - Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

Section 6 of the PCS would amend G.S. 58-50-130(a)(5) to allow insurers to provide stop loss insurance to employers who have 10 or more employees, even if those employers do not comply with the provisions of G.S. 58-50-130.

Section 7 of the PCS would remove self-funded health benefit plans sponsored by nonprofit organizations from regulation under Chapter 58 of the General Statutes, provided that those nonprofit organizations:

- Are incorporated in North Carolina.
- Have been in existence for at least ten years.
- Are classified as nonprofits under Section 501(c) of the Internal Revenue Code.
- Provide membership opportunities in all 100 counties.
- Provide members with representation on the nonprofit's governing board.

EFFECTIVE DATE:

Sections 1 and 2 of this act are effective when it becomes law and apply to applications for licensure submitted on or after that date.

Sections 3 and 4 of this act become effective when at least seven states have enacted the PSYPACT.

Sections 5 and 6 of this act are effective January 1, 2020.

BACKGROUND:

Sections 1 and 2: These sections were recommended by the House Select Committee on School Safety.

Sections 3 and 4: The PSYPACT is a multi-jurisdictional psychology compact. As of June 6, 2018, it had been enacted by six states (Arizona, Nevada, Utah, Colorado, Nebraska, and Missouri). It has been endorsed by the psychology licensing boards in five states (New Mexico, Texas, Georgia, Ohio, and Wisconsin). PSYPACT legislation is currently being considered in Illinois and Rhode Island. These sections were recommended by the Joint Legislative Oversight Committee on Health and Human Services.

Section 5: Stop loss insurance is a type of insurance designed to limit the exposure of entities that self-insure. The entity typically obtains coverage that will pay all losses in excess of a certain self-insured dollar amount.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H D

HOUSE BILL 933
Second Edition Engrossed 5/17/18
PROPOSED SENATE COMMITTEE SUBSTITUTE H933-CSBC-40 [v.3]
6/6/2018 7:17:02 PM

Short Title: Reciprocity/School Psychologist Licensure. (Public)

Sponsors:

Referred to:

May 16, 2018

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO GRANT A LICENSE TO PRACTICE AS A SCHOOL PSYCHOLOGIST TO ANY INDIVIDUALS WHO HOLD THE NATIONALLY CERTIFIED SCHOOL PSYCHOLOGIST CREDENTIAL, ESTABLISHING A PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT), ALLOWING INSURERS TO PROVIDE STOP LOSS INSURANCE TO SMALL BUSINESSES, AND ALLOWING CERTAIN NONPROFIT ORGANIZATIONS TO SPONSOR SELF-FUNDED HEALTH BENEFIT PLANS.

Whereas, school psychologists perform essential services for the social, emotional, and mental health of students throughout North Carolina; and

Whereas, the number of school psychologists in the State has been steadily declining since the 2013-2014 academic year; and

Whereas, one reason the State faces a shortage of school psychologists is the lack of reciprocity granted to individuals who are licensed as school psychologists in other states and may wish to practice in North Carolina; and

Whereas, the standards to receive a Nationally Certified School Psychologist credential from the National Association of School Psychologists are at least as stringent as the standards the State currently requires for licensure as a school psychologist; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 115C-270.20(b) is repealed.

SECTION 1.(b) The catch line of G.S. 115C-270.20 reads as rewritten:

"**§ 115C-270.20. ~~Licensure~~ Teacher licensure requirements.**"

SECTION 2. Article 17E of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-270.21. Administrator and student services personnel licensure requirements.**

(a) Administrators. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for administrators, as provided in this Chapter.

(b) Student Services Personnel. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for student services personnel, as provided in this Article.

The State Board of Education shall issue a school psychologist license to an individual who does any of the following: (i) meets the criteria for licensure as a school psychologist established by the State Board or (ii) holds the Nationally Certified School Psychologist credential issued by the National Association of School Psychologists. For any individual that holds the Nationally Certified School Psychologist credential, a school psychologist license shall be issued to the individual within 60 days of submission of a completed application that includes documentation verifying that credential."

SECTION 3. Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

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

Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance, or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c), or been terminated pursuant to G.S. 90-270.171(b).

(8) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership

organization composed of State and Provincial Psychology Regulatory Authorities.

(9) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies), to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States, the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies), in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State Licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact Privilege to Practice Telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology; criminal background; and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a

program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

(4) No history of adverse action that violate the Rules of the Commission;

(5) No criminal record history that violates the Rules of the Commission;

(6) Possess a current, active IPC;

(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.

(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence

from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists individuals to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Non-confidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one (1) vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;
f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;
g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
h. Disclosure of investigatory records compiled for law enforcement purposes;
i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or
j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;
(2) Providing reasonable standards and procedures:
a. For the establishment and meetings of other committees; and
b. Governing any general or specific delegation of any authority or function of the Commission;
(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;
(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;
(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;
(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rule shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;

(10) To borrow money;

(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

(12) To provide and receive information from, and to cooperate with, law enforcement agencies;

(13) To adopt and use an official seal; and

(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex-officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex-officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has having at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds

that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States.

SECTION 5. G.S. 58-50-130 reads as rewritten:

"**§ 58-50-130. Required health care plan provisions.**

(a) Health benefit plans covering small employers are subject to the following provisions:

…

(5) ~~No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than 26 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act.~~ An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:

a. Provides direct coverage of health expenses payable to an individual.

b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

c. Has an annual aggregate attachment point lower than the greater of one of the following:

1. One hundred twenty percent (120%) of expected claims.

2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis.

..."

SECTION 6. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-8. Certain nonprofit health benefit plans not subject to this Chapter.**

(a) A self-funded health benefit plan sponsored by a nonprofit organization that satisfies the conditions of subsection (b) of this section shall be deemed not to be insurance and not subject to this Chapter.

(b) A nonprofit organization that sponsors a self-funded health benefit plan under this section must satisfy all of the following conditions:

(1) Be incorporated in the State.

(2) Have been in existence for 10 continuous years.

(3) Have been determined by the Internal Revenue Service to be a tax exempt organization under Section 501(c) of the Internal Revenue Code.

(4) Provide membership opportunities for eligible individuals or business entities in all 100 counties of the State.

(5) Provide its members with representation on its governing board and committees.

(c) Two or more nonprofit organizations that individually satisfy the conditions of this section may jointly sponsor a health benefit plan for their members.

(d) A nonprofit organization that sponsors a health benefit plan under this section shall file an annual certification with the Secretary of State demonstrating that the organization satisfies the conditions set forth in subsection (b) of this section. A copy of this certification shall be submitted to the Commissioner.

(e) Nothing in this section shall prohibit a person participating in a self-funded health plan under this section from pursuing the remedies set forth in Article I of Chapter 75 of the General Statutes.

SECTION 7. Sections 1 and 2 of this act are effective when it becomes law and apply to applications for licensure submitted on or after that date. Sections 3 and 4 of this act become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in Section 2 of this act. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in Section 4 of this act has been enacted by seven member states. Sections 5 and 6 of this act are effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

HOUSE BILL 933
Second Edition Engrossed 5/17/18

Short Title:	Reciprocity/School Psychologist Licensure.	(Public)
Sponsors:	Representatives Dobson, Torbett, Lewis, and Lucas (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

May 16, 2018

A BILL TO BE ENTITLED

AN ACT DIRECTING THE STATE BOARD OF EDUCATION TO GRANT A LICENSE TO PRACTICE AS A SCHOOL PSYCHOLOGIST TO ANY INDIVIDUALS WHO HOLD THE NATIONALLY CERTIFIED SCHOOL PSYCHOLOGIST CREDENTIAL, AS RECOMMENDED BY THE HOUSE SELECT COMMITTEE ON SCHOOL SAFETY.

Whereas, school psychologists perform essential services for the social, emotional, and mental health of students throughout North Carolina; and

Whereas, the number of school psychologists in the State has been steadily declining since the 2013-2014 academic year; and

Whereas, one reason the State faces a shortage of school psychologists is the lack of reciprocity granted to individuals who are licensed as school psychologists in other states and may wish to practice in North Carolina; and

Whereas, the standards to receive a Nationally Certified School Psychologist credential from the National Association of School Psychologists are at least as stringent as the standards the State currently requires for licensure as a school psychologist; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 115C-270.20(b) is repealed.

SECTION 1.(b) The catch line of G.S. 115C-270.20 reads as rewritten:

"**§ 115C-270.20. ~~Licensure~~ Teacher licensure requirements.**"

SECTION 2. Article 17E of Chapter 115C of the General Statutes is amended by adding a new section to read:

"**§ 115C-270.21. Administrator and student services personnel licensure requirements.**

(a) Administrators. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for administrators, as provided in this Chapter.

(b) Student Services Personnel. – The State Board shall establish classification and levels of preparation necessary for issuance of licenses for student services personnel, as provided in this Article.

The State Board of Education shall issue a school psychologist license to an individual who does any of the following: (i) meets the criteria for licensure as a school psychologist established by the State Board or (ii) holds the Nationally Certified School Psychologist credential issued by the National Association of School Psychologists. For any individual that holds the Nationally Certified School Psychologist credential, a school psychologist license shall be issued to the individual within 60 days of submission of a completed application that includes documentation verifying that credential."

SECTION 3. This act is effective when it becomes law and applies to applications for licensure submitted on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 933

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

H933-ABC-41 [v.3]

Amends Title [NO]
H933-CSBC-40 [v.3]

Date 6/12 ,2018

Senator Hise

moves to amend PCS H933-CSBC-40 [v.3] on page 17, line 48, through page 18, line 33, by rewriting the lines to read:

"**SECTION 5.** G.S. 58-50-130 reads as rewritten:

"**§ 58-50-130. Required health care plan provisions.**

(a) Health benefit plans covering small employers are subject to the following provisions:

...

(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than ~~26~~ 16 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:

a. Provides direct coverage of health expenses payable to an individual.

b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

c. Has an annual aggregate attachment point lower than the greater of one of the following:

1. One hundred twenty percent (120%) of expected claims.
2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis.

...";

and on page 19, lines 13-14, by rewriting the lines to read:
"been enacted by seven member states. Sections 5 and 6 of this act are effective January 1, 2020."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

Senate Committee On

Health Care

June 12, 2018 – Room 544 LOB – ~~5:00~~ 1:05 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Shaun R. DeJarnette	NCANP
Amy Hawkins ND	NCANP
JARRET BURR	[illegible]
Sarah Wolfe	MWC
Bob Mays	NCDOI
Robert Croom	NCDOI
TED HAMBY	NCDOI
Nicole Dozier	NC Justice Ctr
Brendan Riley	NC Justice Center
Patsy Nelson	American Heart Assn
Peg O'Connell	March of Dimes
LYNN MAHOR	NC DPI
Jeff Kiser	Aetna
Joe Winn	Aetna
DANIEL BEAM	TROUTMAN SANDERS
Susan Fortney	NCMS
Grecar Webb	"

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

June 12, 2018

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	Jordan Price
Chip Baggett	ACMS
Rachel Bradley	[illegible]
[illegible]	SBE
Lori Kroll	Novant Health
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
Dave Richard	DHHS
LT McCrimmon	DHHS
Matt Gray	DHHS
Justin Clayton	Governor
Andy Chase	NCMA
AMES SIMMONS	EQUALITY NC
Doug Myskin	PSG
Pat A. Yancey	NC A NP

09-21-201

Senate Committee On

Health Care

June 12, 2018 – Room 544 LOB – 5:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Betsy McCorkle	KGANC
Dave Horne	SA
Cindy Thomas	Focus Carolina
Dana Simpson	SA
Kara Weisland	SA
Tracy Kimbrell	Parker Poe
Rhaegan Jackson	Focus Carolina
	CSS

Senate Committee On

Health Care

June 12, 2018 – Room 544 LOB – 5:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
LARRY WOOTEN	NC FARM BUREAU
Paul Sherman	NCFB
Angel Sams	D&S
Laura DeVivo	D&S
JAKE PARKER	NCFB
Peter T Daniel	NCFB
Mark Fleming	BCBSNC
Ryan Blackledge	CoreHealth
Will Price	IOG
Becki Gray	JLF
Lexi Arthur	JLF
Joe Stewart	NANC
Amy Auth	30 PR
Richard Bostic	NCSBA
Ben Popkin	Popkin Strategies
Cezy Hand	NCHA
[illegible]	KOK

Senate Committee On

Health Care

June 12, 2018 – Room 544 LOB – 5:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Connie Wilson	ECNC
Bill Scoggin	T3

Senate Committee on Health Care
Wednesday, June 13, 2018 at 3:00 PM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 3:00 PM on June 13, 2018 in Room 643 of the Legislative Office Building. 10 members were present.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by welcoming everyone and recognized the Senate Pages – Gabriela Jones of Asheville, KaLa Keaton or Cary, Lorelei Marsh of Chapel Hill, LeAnna Mintz or Ash, Olivia Lee of Greenville, Sierra Coleman of Raleigh, Jayda Coleman of Raleigh, and Preston Washburn of Mooresville. He also recognized the Sergeants-at-Arms – Eddie Broughton, Tom Burroughs, and Larry Hancock.

HB 998 Improving NC Rural Health. (Representatives Lewis, Murphy, White, Hunter)

Senator Hise recognized Representative Murphy to present HB998 – Improving NC Rural Health. Representative Murphy explained the bill and offered to answer any questions. Senator Krawiec offered an amendment to the bill pertaining to Medicaid Health Outcomes Programs Study. Senator Woodard moved for adoption of the amendment. The motion passed. Senator Jim Davis offered an amendment to the bill pertaining to dental licenses. Senator Davis moved for adoption of the amendment. The motion passed. Senator Hise offered an amendment to the bill pertaining to rural access of dental care. Senator Krawiec moved for adoption of the amendment. The motion passed. Senator Tucker moved for a favorable report to the bill as amended, rolled into a new PCS, unfavorable to the original bill. The motion passed and was referred to Senate Rules Committee.

HB 741 DHHS Study/Maternal and Neonatal Care. (Representatives Murphy, Boswell, Adcock, Cunningham)

Senator Hise recognized Representative Murphy to present HB741 – DHHS Study/Maternal and Neonatal Care. Representative Murphy explained the bill and offered to answer any questions. Senator Krawiec offered an amendment to the bill allowing simultaneous cremation of certain fetuses and infants. Senator Barringer explained the amendment and offered to answer questions. Senator Krawiec moved for adoption of the amendment. The motion passed. Senator Robinson moved for a favorable report to the bill as amended, rolled into a new PCS, unfavorable to the original bill. The motion passed and was referred to Senate Rules Committee.

The meeting adjourned at 3:32 pm.

Senator Ralph Hise, Chair
Presiding

Leigh Ann Biddix, Committee Clerk

Principal Clerk ____
Reading Clerk ____

Updated #4: Time Change to 3:00 PM

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 13, 2018	3:00 PM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 998	Improving NC Rural Health.	Representative Lewis Representative Murphy Representative White Representative Hunter
HB 741	DHHS Study/Maternal and Neonatal Care.	Representative Murphy Representative Boswell Representative Adcock Representative Cunningham

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

Principal Clerk ____
Reading Clerk ____

Updated #3: Time Change to 1:30 PM

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 13, 2018	1:30 PM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 998	Improving NC Rural Health.	Representative Lewis Representative Murphy Representative White Representative Hunter
HB 741	DHHS Study/Maternal and Neonatal Care.	Representative Murphy Representative Boswell Representative Adcock Representative Cunningham

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

Principal Clerk
Reading Clerk

Updated #2: Time Change to 3:00 PM

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 13, 2018	3:00 PM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 998	Improving NC Rural Health.	Representative Lewis Representative Murphy Representative White Representative Hunter
HB 741	DHHS Study/Maternal and Neonatal Care.	Representative Murphy Representative Boswell Representative Adcock Representative Cunningham

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

Principal Clerk
Reading Clerk

Updated #1: Time Change to 2:00 PM

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 13, 2018	2:00 PM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 998	Improving NC Rural Health.	Representative Lewis Representative Murphy Representative White Representative Hunter
HB 741	DHHS Study/Maternal and Neonatal Care.	Representative Murphy Representative Boswell Representative Adcock Representative Cunningham

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

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Wednesday	June 13, 2018	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 998	Improving NC Rural Health.	Representative Lewis Representative Murphy Representative White Representative Hunter
HB 741	DHHS Study/Maternal and Neonatal Care.	Representative Murphy Representative Boswell Representative Adcock Representative Cunningham

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

Senate Committee on Health Care
Wednesday, June 13, 2018, 3:00 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 998	Improving NC Rural Health.	Representative Lewis Representative Murphy Representative White Representative Hunter
HB 741	DHHS Study/Maternal and Neonatal Care.	Representative Murphy Representative Boswell Representative Adcock Representative Cunningham

Adjourn

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Wednesday, June 13, 2018

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

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

HB **741** DHHS Study/Maternal and Neonatal Care.

Draft Number:	H741-PCS10511-BC-50
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

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

HB **998** **(CS#1)** Improving NC Rural Health.

Draft Number:	H998-PCS30522-BP-11
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Tamara Barringer will handle HB 741
Senator Joyce Krawiec will handle HB 998

HOUSE BILL 998:
Improving NC Rural Health.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Reps. Lewis, Murphy, White, Hunter	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	Third Edition		

OVERVIEW: ***HB 998 directs the Department of Health and Human Services (DHHS) to study incentives for medical education in rural areas and assist rural hospitals in becoming designated as teaching hospitals; directs the Office of Rural Health, DHHS, to ensure the loan repayment program is targeted to benefit health care providers in rural areas, and to identify the need for dentists in rural areas; and directs the Program Evaluation Division to study the State Health Plan, and DHHS to study changes to the Medicaid Program; and to improve access to dental care in rural areas.***

HB 998 includes the original content from HB 998, Section 2 of HB 999, and HB 1001, which as introduced were recommendations from the Legislative Research Commission, Committee on Access to Healthcare in Rural NC.

[As introduced, this bill was identical to S742, as introduced by Sens. Curtis, McInnis, Britt, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS: **PART I. GME and New Teaching Hospitals** focuses on health care providers and hospitals in rural NC by requiring DHHS to conduct two studies.

Section 1(a) and (b) require DHHS to study options to incentivize health care providers in rural NC by identifying modifications, enhancements, and other changes to graduate medical education payments to hospitals. In conducting the study, the Department may collaborate with the North Carolina Area Health Education Centers (AHEC) Program. DHHS is required to report to the Joint Legislative Oversight Committee on Health and Human Services (JLOC-HHS) and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC-Medicaid & Health Choice) by October 1, 2018. The report must include specific, actionable steps that can be implemented, along with estimated costs and a timetable for implementation.

Section 2(a) and (b) require DHHS to conduct a study to (i) identify rural hospitals that desire to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services (CMS); (ii) determine the technical assistance those hospitals require in order to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; and (iii) calculate the expected cost for those hospitals to be designated as new teaching hospitals by (CMS). DHHS must provide an interim report by October 1, 2018 and a final report by October 1, 2019, to the JLOC-HHS and the JLOC-Medicaid & Health Choice.

PART II. Target Loan Repayment Programs requires the Office of Rural Health, DHHS, to align the Program with specified goals and to identify the need for dentists in rural areas then develop a recommendation to target Program funds for dentists.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 3(a) directs the Office of Rural Health, DHHS, to structure the North Carolina State Loan Repayment Program to align the Program with the following goals:

(1) Increase the number of health care providers in rural areas of the State.
(2) Coordinate it with the National Health Service Corps and Federal Loan Repayment programs, as well as any other publicly or privately funded programs, to maximize funding in order to increase the number of health care providers in rural areas of the State.
(3) Encourage both recruitment and retention of health care providers in rural areas of the State.

Section 3(b) directs the Office of Rural Health to work with data from the Cecil G. Sheps Center for Health Services Research, and other sources, to identify the need for dentists in rural NC and to develop a recommendation to target loan repayment funds for dentists in rural areas that have been identified as having the greatest need.

Section 3(c) requires the Office of Rural Health to provide an interim report by October 1, 2018, and a final report by October 1, 2019, on the requirements in this section to the JLOC-HHS.

PART III. Study State Health Plan and Medicaid requires the Program Evaluation Division to study the State Health Plan and DHHS to study Medicaid to determine methods to increase preventative health services, improve health outcomes, and lower the overall cost of care.

Section 4 requires the Joint Legislative Program Evaluation Oversight Committee to include in the work plan of the Program Evaluation Division an evaluation of the State Health Plan to determine whether there are changes that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study shall determine the following: (i) the contract options for improving primary care provider quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model and (ii) the total cost implications and legislation needed to implement recommendations. The Program Evaluation Division shall report its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee on or before March 1, 2019

Section 5 requires DHHS to study the impact of the Medicaid program on the health of individuals residing in rural areas of the State, including access to care and the effect on population health outcomes, including the impact of the Medicaid program on the economies of these rural areas. DHHS must also study whether there are changes to the Medicaid program that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study shall determine the following: (i) how options will relate to the outcome measures that will be included in Prepaid Health Plan contracts under the transformed Medicaid program, (ii) the contract options for improving primary care provider quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model, (iii) any recommendations to improve rural access to health care through the Medicaid program, and (iv) the total cost implications and legislation needed to implement recommendations. The Department is required to report its findings and recommendations to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on or before October 1, 2019

PART IV. Improve Access to Dental Care seeks to increase access to dental care for residents of rural areas in addition to the efforts in Section 3(b).

Section 6(b) amends G.S. 90-36 to require the North Carolina State Board of Dental Examiners to issue a license by credentials to any dentist who applies for a license by credentials and who holds a current license and is in good standing with the licensing jurisdiction in one of the four states that border North Carolina provided that the dental board of the border state will also issue a license by credentials to a dentist having a license to practice in North Carolina. The requirements of subsections (b), (c), (d), and

(e) of this section shall apply to any dentist who applies for a license by credentials from a border state in accordance with the new subsection.

EFFECTIVE DATE: Section 6(b) would become effective October 1, 2018. The remainder of the act would become effective when it becomes law.

HOUSE BILL 998*
Committee Substitute Favorable 6/6/18
Third Edition Engrossed 6/11/18

Short Title: Improving NC Rural Health. (Public)

Sponsors:

Referred to:

May 24, 2018

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY AND REPORT RECOMMENDATIONS TO CREATE INCENTIVES FOR MEDICAL EDUCATION IN RURAL AREAS OF THE STATE AND TO ASSIST RURAL HOSPITALS IN BECOMING DESIGNATED AS TEACHING HOSPITALS BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; TO DIRECT THE OFFICE OF RURAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO ENSURE ITS LOAN REPAYMENT PROGRAM IS TARGETED TO BENEFIT HEALTH CARE PROVIDERS IN RURAL NORTH CAROLINA, INCLUDING IDENTIFYING AND MAKING RECOMMENDATIONS TO ADDRESS THE NEED FOR DENTISTS IN RURAL AREAS; AND TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY THE STATE HEALTH PLAN AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY THE IMPACT OF THE MEDICAID PROGRAM ON THE HEALTH OF INDIVIDUALS RESIDING IN RURAL AREAS OF THE STATE, AS WELL AS ON THE ECONOMIES OF THESE RURAL AREAS, AND ANY CHANGES TO THE MEDICAID PROGRAM THAT WILL INCREASE PREVENTATIVE HEALTH SERVICES, IMPROVE HEALTH OUTCOMES, AND LOWER THE COST OF CARE; AND TO IMPROVE ACCESS TO DENTAL CARE IN RURAL NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. GME AND NEW TEACHING HOSPITALS

SECTION 1.(a) The Department of Health and Human Services shall conduct a study to identify options for modification, enhancements, and other changes to graduate medical education payments to hospitals, as well as any other reimbursements, to incentivize health care providers in rural areas of the State to (i) participate in medical education programs exposing residents to rural areas, programs, and populations and (ii) support medical education and medical residency programs in a manner that addresses the health needs in the State. In conducting the study, the Department may collaborate with the North Carolina Area Health Education Centers Program. The study shall examine at least all of the following:

(1) Changes in Medicaid graduate medical education reimbursement and funding sources after the 1115 Medicaid waiver submitted by the Department to the Centers for Medicare and Medicaid Services is approved, including how the changes vary from the current model, the rationale for the changes, and the specific incentives the new structure creates for urban and rural hospitals.

(2) Options to coordinate North Carolina Area Health Education Centers funding to create incentives for attracting residents and students to rural areas of the State, with the goal of ensuring the maximum benefit of the funding.

(3) Any other issues the Department deems appropriate.

SECTION 1.(b) The Department shall report its findings to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018. The report must include specific, actionable steps that can be implemented, along with estimated costs and a timetable for implementation.

SECTION 2.(a) The Department of Health and Human Services shall conduct a study to (i) identify rural hospitals that desire to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; (ii) determine the technical assistance those hospitals require in order to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services; and (iii) calculate the expected cost for those hospitals to be designated as new teaching hospitals by the Centers for Medicare and Medicaid Services. In conducting this study, the Department shall engage external professionals with experience and expertise in the establishment of new teaching programs, expanding existing programs, and maximizing the effectiveness of funding for medical education, particularly in rural areas. The study shall examine at least all of the following:

(1) Expansion of graduate medical education payments to outpatient costs and services.

(2) Modifications to cost-finding and reimbursement formulas that incentivize rural hospitals to participate in education programs.

(3) Options in physician reimbursement to incentivize participation, including a graduate medical education or geographic add-on for rural areas of the State.

(4) Any other issues the Department deems appropriate.

SECTION 2.(b) The Department shall provide an interim report of its findings to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2018. The Department shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by October 1, 2019.

PART II. TARGET LOAN REPAYMENT PROGRAMS

SECTION 3.(a) The Office of Rural Health, Department of Health and Human Services, is directed to structure the North Carolina State Loan Repayment Program so that it is aligned with all of the following goals:

(1) The Program is targeted to increase the number of health care providers in rural areas of the State.

(2) The Program is coordinated with the National Health Service Corps and Federal Loan Repayment programs, as well as any other publicly or privately funded programs, to maximize funding in order to increase the number of health care providers in rural areas of the State.

(3) The Program encourages both recruitment and retention of health care providers in rural areas of the State.

SECTION 3.(b) The Office of Rural Health, Department of Health and Human Services, is directed to work with data from the Cecil G. Sheps Center for Health Services Research, and other sources, to identify the need for dentists in rural areas in North Carolina and to develop a recommendation to target loan repayment funds for dentists in rural areas that have been identified as having the greatest need for dentists.

SECTION 3.(c) On or before October 1, 2018, the Office of Rural Health, Department of Health and Human Services, shall provide an interim report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section. On or before October 1, 2019, the Office of Rural Health, Department of Health and Human Services, shall provide a final report to the Joint Legislative Oversight Committee on Health and Human Services on the actions required by this section.

PART III. STUDY STATE HEALTH PLAN AND MEDICAID

SECTION 4. The Joint Legislative Program Evaluation Oversight Committee shall include in the work plan of the Program Evaluation Division an evaluation of the State Health Plan to determine whether there are changes that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study shall determine the following: (i) the contract options for improving primary care provider quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model and (ii) the total cost implications and legislation needed to implement recommendations. The Program Evaluation Division shall report its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee on or before March 1, 2019.

SECTION 5. The Department of Health and Human Services (Department) shall study the impact of the Medicaid program on the health of individuals residing in rural areas of the State, including access to care and the effect on population health outcomes. The Department shall also study the impact of the Medicaid program on the economies of these rural areas. Further, the Department shall study whether there are changes to the Medicaid program that will increase preventative health services, improve health outcomes, and lower the overall cost of care. The alternatives studied should include evaluation of the direct primary care model. The study shall determine the following: (i) how options will relate to the outcome measures that will be included in Prepaid Health Plan contracts under the transformed Medicaid program, (ii) the contract options for improving primary care provider quality of life in a rural setting that include, but are not limited to, a direct primary care type payment model, (iii) any recommendations to improve rural access to health care through the Medicaid program, and (iv) the total cost implications and legislation needed to implement recommendations. The Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on or before October 1, 2019.

PART IV. IMPROVE ACCESS TO DENTAL CARE

SECTION 6.(a) In addition to the efforts in Section 3(b) of this act, residents of rural areas will benefit from increased access to dental care provided by expediting the license by credentials process for dentists in states that border North Carolina.

SECTION 6.(b) G.S. 90-36 reads as rewritten:

"**§ 90-36. Licensing practitioners of other states.**

(a) The North Carolina State Board of Dental Examiners may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications, is in good standing with the licensing jurisdiction, has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board, and meets all other requirements of this section and rules adopted by the Board. The Board may conduct examinations and interviews to test the qualifications of the applicant and may require additional information that would affect the applicant's ability to render competent dental care. The Board may, in its discretion, refuse to issue a license by credentials to an applicant who the Board determines is unfit to practice dentistry.

(a1) The North Carolina State Board of Dental Examiners shall issue a license by credentials to any dentist who applies for a license by credentials and who holds a current license and is in good standing with the licensing jurisdiction in one of the four states that border North Carolina provided that the dental board of the border state will also issue a license by credentials to a dentist having a license to practice in North Carolina. The requirements of subsections (b), (c), (d), and (e) of this section shall apply to any dentist who applies for a license by credentials from a border state in accordance with this subsection.

(b) The applicant for licensure by credentials shall be of good moral character and shall have graduated from and have a DDS or DMD degree from a program of dentistry in a school or college accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.

(c) The applicant must meet all of the following conditions:

(1) Has been actively practicing dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), for a minimum of five years immediately preceding the date of application.

(2) Has not been the subject of final or pending disciplinary action in the Armed Forces of the United States, in any state or territory in which the applicant is or has ever been licensed to practice dentistry, or in any state or territory in which the applicant has held any other professional license.

(3) Presents evidence that the applicant has no felony convictions and that the applicant has no other criminal convictions that would affect the applicant's ability to render competent dental care.

(4) Has not failed an examination conducted by the North Carolina State Board of Dental Examiners.

(d) The applicant for licensure by credentials shall submit an application to the North Carolina State Board of Dental Examiners, the form of which shall be determined by the Board, pay the fee required by G.S. 90-39, successfully complete examinations in Jurisprudence and Sterilization and Infection Control, and meet the criteria or requirements established by the Board.

(e) ~~The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued.~~ The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina. However, when a dentist licensed under this section faces possible Board action to void the dentist's license for failure to limit the dentist's practice to North Carolina, if the dentist demonstrates to the Board that out-of-state practice actions were in connection with formal contract or employment arrangements for the dentist to provide needed clinical dental care to patients who are part of an identified ethnic or racial minority group living in a region of the other state with low access to dental care, the Board, in its discretion, may waive the in-State limitations on the out-of-state practice for a maximum of 12 months."

PART V. EFFECTIVE DATE

SECTION 7. Section 6(b) of this act becomes effective October 1, 2018. The remainder of this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 998*

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

H998-ATR-9 [v.2]

Amends Title [YES]
Third Edition

Date 6/13/ ,2018

Senator Krawiec

moves to amend the bill on page 1, line 19, by deleting the word "CAROLINA." and adding the following at the end of the line:

"CAROLINA; AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY MEDICAID HEALTH OUTCOMES PROGRAMS.";

and to amend the bill on page 4, lines 43 through 44, by rewriting the lines to read:

"PART V. MEDICAID HEALTH OUTCOMES PROGRAMS STUDY

SECTION 7.(a) The Department of Health and Human Services (Department) shall conduct a study to propose two coordinated quality outcomes programs that are consistent with subdivision (7) of Section 4 of S.L. 2015-245 requiring that the State's transformed Medicaid delivery system be built on defined measures and goals for risk-adjusted health outcomes and quality of care subject to specific accountability measures. One program shall be designed to apply to all acute care hospitals participating in the State Medicaid program. Another program shall be designed to apply to all Medicaid Prepaid Health Plans in the State. Components to be included in the proposed programs are as follows:

(1) The programs shall be designed to reduce unnecessary and inappropriate service utilization by providing hospitals and Prepaid Health Plans with information and incentives to reduce potentially avoidable hospital admissions, hospital readmissions, and emergency department visits.

(2) The programs shall be designed to generate sustainable savings within the Medicaid program that are quantifiable within a three-year period following implementation.

(3) The programs shall be initiated with comprehensive analysis of State Medicaid databases to identify potentially avoidable events causing waste in the Medicaid system. The Department shall establish the methodology for identifying potentially avoidable events, that is, to the extent possible, consistent with methodologies utilized by other state Medicaid programs or commercial payers. For hospitals and Prepaid Health Plans, potentially avoidable events shall include potentially avoidable hospital readmissions and complications. For Prepaid Health Plans, potentially avoidable events shall

also include potentially avoidable hospital admissions and emergency department visits.

(4) The programs shall include the establishment of benchmarks for measurement of outcomes and cost savings related to potentially avoidable events for each program, based on the incidence and cost of potentially avoidable events identified through the comprehensive analysis.

(5) The programs shall include the establishment of a potentially avoidable events reporting system for hospitals and Prepaid Health Plans and monitoring of this system.

(6) The programs shall include financial incentives related to the reduction of potentially avoidable events by hospitals and Prepaid Health Plan utilizing value-based payments consistent with sub-subdivision a. of subdivision (5) of Section 5 of S.L. 2015-245.

SECTION 7.(b) No later than October 1, 2018, the Department shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice containing the proposed programs required by this section. This report shall also contain the following information:

(1) Specific, measurable, details of each component of the programs, including the time frame for implementation of each component and a description of the measurable improvement in health outcomes that the programs are designed to achieve.

(2) An estimate of the cost to implement the programs, and a description of all other resources that would be needed to implement the programs.

(3) A projected estimate of the savings that would be generated as a result of the achievement of the proposed outcomes and quality measures included in the two programs. This estimate shall (i) identify the portion of savings that is projected to be achieved by the State, and (ii) identify how the estimated savings will be achieved in addition to anticipated savings associated with the management functions to be performed by Prepaid Health Plans under the transformed Medicaid system.

(4) Any anticipated barriers to implementation of the programs.

(5) A detailed description of any other initiatives or programs the Department is planning that will accomplish similar objectives.

PART VI. EFFECTIVE DATE

SECTION 8. Section 6(b) of this act becomes law effective October 1, 2018. The".

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 998*

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

H998-ATR-9 [v.2]

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 998*

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

H998-ASH-46 [v.3]

Amends Title [NO]
Third Edition

Date 6/13 ,2018

Senator J. Davis

moves to amend the bill on page 4, line 6 by rewriting the line to read:

"(c) and (d) of this section shall apply to any dentist who applies for a license by credentials";

and to amend the bill on page 4, lines 30-41, by rewriting the lines to read:

"~~(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina. However, when a dentist licensed under this section faces possible Board action to void the dentist's license for failure to limit the dentist's practice to North Carolina, if the dentist demonstrates to the Board that out-of-state practice actions were in connection with formal contract or employment arrangements for the dentist to provide needed clinical dental care to patients who are part of an identified ethnic or racial minority group living in a region of the other state with low access to dental care, the Board, in its discretion, may waive the in-State limitations on the out-of-state practice for a maximum of 12 months~~.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 998*

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

H998-ASH-45 [v.2]

Amends Title [YES]
Third Edition

Date 6/13 ,2018

Senator Hise

moves to amend the bill on page 1, lines 11 through 19, by rewriting the lines to read:

"RURAL AREAS; AND TO IMPROVE ACCESS TO DENTAL CARE IN RURAL NORTH CAROLINA.";

and to amend the bill on page 3, line 8, through line 33, by deleting the lines..

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 741:
DHHS Study/Maternal and Neonatal Care.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2018
Introduced by:	Reps. Murphy, Boswell, Adcock, Cunningham	**Prepared by:**	Jason Moran-Bates
Analysis of:	First Edition		Staff Attorney

OVERVIEW: House Bill 741 would direct the Department of Health and Human Services (DHHS) to study and report on North Carolina's ability to provide access to high-quality, risk-appropriate maternal and neonatal care.

BILL ANALYSIS:

Section 1.(a) of the bill would direct DHHS to study North Carolina's ability to provide timely and equitable access to high-quality, risk-appropriate maternal and neonatal care. The study must examine the following:

- The complexity levels of care by all delivering hospitals in caring for birth mothers and newborns.
- The current management of referral and transportation to different facilities and specialty providers.
- Disparities in access to risk-appropriate maternal and hospital care.
- Service gaps.
- Issues impacting the ability to match patient need with provider skill.
- Recommendations to ensure women in North Carolina receive quality prenatal care and to ensure that mothers and newborns are cared for in a facility that can meet their needs.
- Any other issues DHHS deems relevant to the study.

Section 1.(b) of the bill would require DHHS to make in interim report of its findings and recommendations to the 2018 Regular Session of the 2017 General Assembly on or before May 1, 2018, and to make a final report of its findings and recommendations, including proposed legislation, to the 2019 General Assembly.

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

Karen Cochrane-Brown
Director

H741-SMBC-132 E1 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 741

Short Title:	DHHS Study/Maternal and Neonatal Care.	(Public)
Sponsors:	Representatives Murphy, Boswell, Adcock, and Cunningham (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health	

April 13, 2017

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY ISSUES PERTAINING TO HIGH-QUALITY, RISK-APPROPRIATE MATERNAL AND NEONATAL CARE.

Whereas, pregnant and postpartum women require timely, comprehensive medical services matched to their clinical complexity; and

Whereas, medically complex pregnant mothers and newborns should be cared for in a medical facility that can meet their specific medical needs; and

Whereas, maternity and newborn care providers are not geographically distributed to best meet health care needs; and

Whereas, studies have demonstrated that timely access to risk appropriate neonatal and obstetric care can reduce infant mortality and maternal severe morbidity and mortality; and

Whereas, health care facilities across North Carolina have varied capabilities to care for mothers and newborns with complex needs; and

Whereas, designating facilities with specific "levels of care" offers uniform criteria about the capability of health care facilities to provide complexity of care to pregnant women and newborns; and this approach is endorsed by the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the American Academy of Pediatrics, and a number of other national medical organizations; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services shall study and analyze North Carolina's ability to provide women with timely and equitable access to high-quality, risk-appropriate maternal and neonatal care. The study shall examine at least all of the following:

(1) The complexity levels of care currently being provided by all delivering hospitals in caring for birth mothers and newborns.

(2) How current systems of referral and transport to different facilities and specialty providers based on patient risk are being managed.

(3) Disparities in access to risk-appropriate maternal and hospital care.

(4) Service gaps.

(5) Issues that impact the ability to most appropriately match patient need with provider skill.

(6) Recommendations for actionable steps that can be taken in North Carolina to best ensure that pregnant women receive quality prenatal care and that

mothers and newborns are cared for in a facility that can meet their specific clinical needs.

(7) Any other issues the Department deems relevant to this study.

SECTION 1.(b) The Department shall make an interim report of its findings and recommendations to the 2018 Regular Session of the 2017 General Assembly on or before May 1, 2018, and a final report of its findings and recommendations, including any recommended legislation, to the 2019 General Assembly.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 741

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

H741-ABC-44 [v.4]

Amends Title [YES]
First Edition

Date 6/13 ,2018

Senator Krawiec

moves to amend the bill on page 1, line 4, by rewriting the line to read:
"MATERNAL AND NEONATAL CARE; AND TO ALLOW SIMULTANEOUS CREMATION OF CERTAIN FETUSES AND INFANTS.";

and on page 2, lines 4-7, by rewriting the lines to read:
"**SECTION 1.(b)** The Department shall make an interim report of its findings and recommendations to the 2019 Regular Session of the 2019 General Assembly on or before May 1, 2019, and a final report of its findings and recommendations, including any recommended legislation, to the 2020 General Assembly.";

and on page 2, line 8, by rewriting the line to read:
"**SECTION 2.** G.S. 90-210.129 reads as rewritten:
"**§ 90-210.129. Cremation procedures.**
...
(h) The simultaneous cremation of the human remains of more than one person within the same cremation chamber is ~~forbidden.~~forbidden, provided that the following human remains may be cremated simultaneously upon the express written direction of the authorized agent:
(1) The human remains of multiple fetuses from the same mother and the same birth.
(2) The human remains of multiple persons up to the age of one year old from the same mother and the same birth.
..."

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 741

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

H741-ABC-44 [v.4]

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

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Senate Committee on Health Care

June 13, 2018 – Room 643 LOB – 3:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Cameron	NCHA
Jay Lanier	c4k
CS Hollis	CSX
Sarah Wolfe	NWC
Matt Gray	DHHS
Devi Arthur	JLF
Jon Carr	Jordan Price
DAVID Kabakchiev	N.C. Board of Nursing
Stephen Kouba	KMA
Amanda Donovan	KTS
Carol Maranel	Gov. office intern
Elizabeth Jackson	student
[illegible]	[illegible]
Logan Martin	Benchmarker
Kelle Hatcher	CFTF
[illegible]	[illegible]
Pierce Blakeway	JDA
[illegible]	NMRC

Senate Committee on Health Care

June 13, 2018 – Room 643 LOB – 3:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Tyler Ford	McGuireWoods
	CDS
EIL	NCBA
AMOS SIMMONS	EQUALITY NC
Sherea Wodicka	NC Alliance of YMCAs
Sarah Lisson	YMCA of the Triangle
Sally Smith	Murphy's intern
Brendan Riley	NC Justice Center
	NCChild
	CCR
Ben Popkin	Popkin Strategies
	MVA
	WakeMed
Chip Baggett	NCMS
Lanier Hodges	UNC HCS
	Vidant

Senate Committee on Health Care

June 13, 2018 – Room 643 LOB – 3:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Ryan Blackledge	ConvHealthD
Hugh Johnson	NCAE
Martha Bolick	PPNB
Morgan Dunn	Walk With
Grace Irish	
Thu Le	CCA
Scott Laster	KGAAC
Kristen Laster	KGAAC
Dana Simpson	SA

Senate Committee on Health Care

June 13, 2018 – Room 643 LOB – 3:00 PM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Joey Peters	CSS
[illegible]	CSS
Jeff Horton	NC Senior Living Assoc.
Sarah Boles	Brickstreet Consulting

Senate Committee on Health Care
Tuesday, December 4, 2018 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on December 4, 2018, in Room 643 of the Legislative Office Building. Thirteen members were present.

Sen. Ralph Hise, Chair, presided. There were no pages. Sergeants-at-Arms were John Enloe, Billy Fritscher, and Hal Roach.

Sen. Hise recognized Sen. Jackson who explained House Bill 1108 – PED/Inmate Pharmacy Purchasing/Monitoring. He then recognized Sen. Newton who sent forth and explained an amendment. Sen. Newton then moved for adoption of the amendment; the motion passed. Sen. Jackson continued explaining the amended bill.

Sen. Hise then recognized Rep. Davis, a primary sponsor of the bill, who provided further background on the bill.

The following were recognized and spoke on the bill: Kenneth Lassiter, Director of Prisons; Dr. Anita Wilson, Medical Director for DPS Health Services; Janet Thomas, DPS Pharmacy Services Director; Lanier Hodgson, Vice President, State and Federal Relations at UNC Health Care System & School of Medicine; Brent Lucas, NCGA Program Evaluation Division; and John Turcotte, Director, Program Evaluation Division.

Sen. Hise also recognized Senators Krawiec, D. Davis, Woodward, Wells to speak on the bill, and welcomed Sen. Horner to the Committee.

Sen. Wells moved for a favorable report to the bill as amended, rolled into a PCS unfavorable as to the original bill. The motion passed. The bill was referred to Rules.

The meeting adjourned at 10:45 AM.

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Senate Committee on Health Care
Tuesday, December 4, 2018, 10:00 AM
643 Legislative Office Building

AGENDA

Senator Hise, Presiding

Welcome and Opening Remarks

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 1108	PED/Inmate Pharmacy Purchasing/Monitoring.	Representative Horn Representative Davis

Adjournment

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Tuesday	December 4, 2018	10:00 AM	643 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1108	PED/Inmate Pharmacy Purchasing/Monitoring.	Representative Horn Representative Davis

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

HOUSE BILL 1108:
PED/Inmate Pharmacy Purchasing/Monitoring.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	December 3, 2018
Introduced by:	Reps. Horn, Davis	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to First Edition H1108-CSBC-52		

OVERVIEW: The Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine the efficiency and economy of inmate healthcare. This bill focuses on pharmaceutical-related expenditures for inmates, which totaled $72.7 million in Fiscal Year 2016–17, an 88% ($33.9 million) increase from five years ago.

Section 1: Directs the Legislative Services Commission to contract with an expert in the HRSA 340B program to develop an HRSA-compliant program for purchasing medications for the treatment of HIV/AIDS, hepatitis C, cancer, neurological conditions, rheumatic diseases, and other costly medical conditions through a Disproportionate Share Hospital. Section 1 also directs the Director of the Budget to increase the budget of the General Assembly by $25,000 to fund the contract.

Section 2: Directs DPS Health Services to revise its medication administration protocol to require supplies of certain medications worth more than $1,000 to be designated as Direct Observation Therapy. DPS Health Services is to report to the Joint Legislative Oversight Committee on Justice and Public Safety on this change in policy.

Section 3: Directs DPS to collect additional data on medications lost during the inmate transfer process, establish internal oversight, controls, and audit activities to limit such losses, and report to the Joint Legislative Oversight Committee on Justice and Public Safety.

Section 4: Directs DPS Health Services to develop a statewide reimbursement, based on the North Carolina State Health Plan for Teachers and State Employees reimbursement rate, for local purchasing of limited quantities of medications and develop a data collection and oversight mechanism to ensure adherence to the short-supply policy for local medication purchases. DPS Health Services is to report to the Joint Legislative Oversight Committee on Justice and Public Safety on efforts to award this contract.

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

Kory Goldsmith of Legislative Drafting substantially contributed to this summary.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H 2

HOUSE BILL 1108*
Committee Substitute Favorable 11/29/18

Short Title: PED/Inmate Pharmacy Purchasing/Monitoring. (Public)

Sponsors:

Referred to:

November 29, 2018

A BILL TO BE ENTITLED

AN ACT TO MODIFY INMATE PHARMACY PURCHASING AND MONITORING.

The General Assembly of North Carolina enacts:

PURCHASING OF CERTAIN INMATE MEDICATIONS

SECTION 1.(a) The Legislative Services Commission through the Legislative Services Office shall contract for a consultant with expertise in the United States Health Resources and Services Administration (HRSA) 340B program to prepare a proposal for the HRSA-compliant purchasing of inmate medications through a Disproportionate Share Hospital (DSH), including, but not limited to, the University of North Carolina Health Care System (UNCHCS). In developing the proposal, UNCHCS and the Department of Public Safety, Health Services Section (DPS Health Services), shall provide the consultant any data or documents determined necessary by the consultant to prepare the proposal. The proposal shall include, but not be limited to, mechanisms for the purchasing of drugs for treating HIV/AIDS, Hepatitis C, cancer, neurological conditions, rheumatic diseases, and other costly medical conditions. In addition, the proposal shall include methods to implement purchasing using (i) a DSH's current on- or off-site clinics, (ii) current DPS clinics, and (iii) telemedicine. The consultant shall submit the proposal, including any proposed legislation necessary for implementation, to the Legislative Services Office and the Joint Legislative Oversight Committee on Justice and Public Safety on or before May 1, 2019.

SECTION 1.(b) The Director of the Budget shall increase the budget of the General Assembly from the Unappropriated Balance Remaining in S.L. 2018-5, Sec. 2.2(a) by twenty-five thousand dollars ($25,000) for the 2018-2019 fiscal year to provide for costs associated with contracting with the consultant described in Section 1.(a) of this act.

REVISION TO MEDICATION ADMINISTRATION PROTOCOL

SECTION 2. The DPS Health Services Section shall revise its policies and procedures to reflect that any supply of a prescription for the treatment of conditions other than HIV with a per-supply value of one thousand dollars ($1,000) or more be designated as Direct Observation Therapy. The Department shall report to the Joint Legislative Oversight Committee on Justice and Public Safety by October 1, 2019, regarding the revised policies and procedures.

COLLECTION OF DATA ON MEDICATIONS LOST DURING INMATE TRANSFER AND ESTABLISHMENT OF INTERNAL CONTROLS TO LIMIT THESE LOSSES

SECTION 3.(a) Part 2 of Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-707.6. Medication losses related to inmate transfer.**

(a) The Health Services Section shall collect data on medication losses that occur during inmate transfer. The collection methods shall provide, at a minimum, for all of the following:

(1) A mechanism to easily summarize medication losses across all identified reasons for the loss.

(2) Information on the prison from which an inmate was transferred.

(3) Identification of custody officials involved in the transfer.

(b) The Department shall develop internal controls related to the oversight of medications lost during inmate transfers based on the data collected under subsection (a) of this section. In addition, the Department's Internal Audit unit shall establish an internal oversight function to investigate any medication losses valued at greater than two hundred dollars ($200.00).

(c) The Department shall also establish disciplinary actions for staff who are found to be responsible for inmate medication losses during transfer. The Health Services Section shall be responsible for addressing disciplinary actions for DPS Health Services prison staff who are found to be responsible for medications lost during inmate transfers and shall refer incidents involving custody staff to the appropriate unit for action."

SECTION 3.(b) DPS shall initiate an internal audit of its processes for transporting medications during inmate transfer. The audit shall examine all medication losses incurred during Fiscal Year 2018–2019 and shall include recommendations to improve controls and promote accountability for medication losses. DPS shall submit the audit to the Joint Legislative Oversight Committee on Justice and Public Safety by December 1, 2019.

CONTRACT WITH STATEWIDE RETAIL PHARMACIES, DATA COLLECTION, AND OVERSIGHT MECHANISM

SECTION 4.(a) Part 2 of Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-707.7. Contract for limited use of local purchase of inmate pharmacy needs.**

(a) The Health Services Section shall adopt a statewide reimbursement for local purchases of limited quantities of medicine. The statewide reimbursement rate shall be based on the North Carolina State Health Plan for Teachers and State Employees reimbursement rate for prescription drugs. Any pharmacy willing to accept the statewide reimbursement rate shall have the right to participate in the plan.

(b) The Health Services Section shall obtain monthly electronic invoices of prescriptions filled by each prison from the vendor chosen under subsection (a) of this section and shall develop a mechanism to collect information on purchases made outside the contract. At a minimum, the following information shall be collected for each prescription: (i) the inmate's prison, (ii) the requesting provider, (iii) the medication requested, (iv) the quantity of the medication requested, and (v) the total value of the prescription.

(c) The Department shall establish a formal oversight mechanism to ensure prescriptions written by providers to be filled at local pharmacies do not exceed the quantities specified in the Department's policy. The Health Services Section central office shall be responsible for implementing the oversight function, shall use the data collected under subsections (a) and (b) of this section to implement the function, and shall implement corrective and disciplinary actions as needed."

SECTION 4.(b) The Department shall report to the Joint Legislative Oversight Committee on Justice and Public Safety by November 1, 2019, on its efforts to award the contract required under subsection (a) of this section.

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

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1108*

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

H1108-AMM-63 [v.3]

Amends Title [NO]
Second Edition

Date _____,2018

Senator _____

moves to amend the bill on page 1, by deleting lines 21-24 and substituting the following:

"**SECTION 1.(b)** Of the funds appropriated in Section 36.2(a) of S.L. 2018-5 to the General Assembly Legislative Services Office to develop a State Government Facilities Master Plan, up to twenty-five thousand dollars ($25,000) shall be used to provide for the costs associated with contracting with the consultant described in Section 1.(a) of this act.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

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

Tuesday, December 04, 2018

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

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

HB **1108 (CS#1)** PED/Inmate Pharmacy Purchasing/Monitoring.

Draft Number:	H1108-PCS30555-BC-53
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Brent Jackson will handle HB 1108

CMR876-V-2

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

December 4, 2018

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Resha Fortson	SEANC
Janet Thomas	NC DPS
Anita Wilson MD	NC DPS
Kenneth Lassiter	NC DPS
Reuben Young	NC DPS
Susanna Davis	NC DPS
	NCDPS
Amber Harris	NCAICC
Ardis Watkins	SEANC
Lanier Hodgson	UNC HCS
Kara Weishaar	SA
Elizabeth Robinson	NCRMA
Andy Ellen	NCRMA
SueAnn Forest	NCMS
Amanda Donovan	KTS
Mike Jones	ACP

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

December 4, 2018

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
John Hazelton	MFS
Joe Stewart	~~LA~~ MA
Bob Maye	DOI
	CSS
Lawrence Jordan	Camelot Academy
Blaze Theil	camelot academy
Megan Miller	Camelot Academy
David Madugu	Camelot Academy
	Camelot Academy
Matthew Wilhelm	Camelot Academy
Sydney Kamin	Camelot Academy
Sylvia Xu	Camelot Academy
Ada Liu	Camelot Academy
John Ward	Camelot Academy
Kevin Cui	Camelot Academy
Chris Shaffner	Citizen

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

December 4, 2018

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Thom Moar	C GA
Cad Thaxe	focus reg
Mah Gras	DHHS
Joyce Peters	CSS
Rachel Bales	PBLA
LT McCrimmon	DHHS
Kari Travis	

VISITOR REGISTRATION SHEET

Senate Committee on Health Care

December 4, 2018

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Tom Fetzer	FSP
Michelle Wells	NCRPA
JOE LANIER	FCOURTMAN
David Ferrell	NP