

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2021

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HOUSE BILL 149  
Committee Substitute Favorable 5/5/21  
Senate Health Care Committee Substitute Adopted 5/26/22  
Fourth Edition Engrossed 6/1/22

Short Title: Expanding Access to Healthcare.

(Public)

Sponsors:

Referred to:

February 25, 2021

1 A BILL TO BE ENTITLED  
2 AN ACT EXPANDING ACCESS TO HEALTHCARE IN NORTH CAROLINA.  
3 The General Assembly of North Carolina enacts:

4  
5 **PART I. MEDICAID**

6  
7 **NC HEALTH WORKS**

8 **SECTION 1.1.(a)** Section 3 of S.L. 2013-5 is repealed.

9 **SECTION 1.1.(b)** G.S. 108A-54.3A is amended by adding a new subdivision to  
10 read:

11 "(24) Individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security  
12 Act who are in compliance with any work requirements established in the  
13 State Plan and in rule. Coverage for individuals under this subdivision is  
14 available through an Alternative Benefit Plan that is established by the  
15 Department consistent with federal requirements, unless that individual is  
16 exempt from mandatory enrollment in an Alternative Benefit Plan under 42  
17 C.F.R. § 440.315."

18 **SECTION 1.1.(c)** This section is effective July 1, 2023, or on the date that the work  
19 requirements developed under Part II of this act become effective, whichever is earlier.

20 **SECTION 1.2.(a)** Part 6 of Article 2 of Chapter 108A of the General Statutes is  
21 amended by adding a new section to read:

22 **§ 108A-54.3B. Nonfederal share of NC Health Works costs.**

23 (a) As used in this section, the following definitions apply:

24 (1) "Cost" means all expenses incurred by the State and counties that are eligible  
25 for Medicaid federal financial participation.

26 (2) "NC Health Works" means the provision of Medicaid coverage to the  
27 individuals described in G.S. 108A-54.3A(24).

28 (b) It is the intent of the General Assembly to fully fund the nonfederal share of the cost  
29 of NC Health Works through a combination of the following sources:

30 (1) Increases in revenue from the gross premiums tax under G.S. 105-228.5 due  
31 to NC Health Works.

32 (2) Increases in intergovernmental transfers due to NC Health Works.

33 (3) Excluding any State retention, the hospital health advancement assessment  
34 under Part 3 of Article 7B of Chapter 108A of the General Statutes.



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1           (4) Savings to the State attributable to NC Health Works that correspond to State  
2           General Fund budget reductions to other State programs.

3           (c) By October 1 of each year, beginning in 2024, the Department shall submit a report  
4 to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of  
5 State Budget and Management, and the Fiscal Research Division containing all of the following  
6 information with supporting calculations:

7           (1) The total nonfederal share of the cost of NC Health Works for the preceding  
8           State fiscal year and the total funding available from the sources described in  
9           subsection (b) of this section.

10          (2) The projected total nonfederal share of the cost of NC Health Works for the  
11          current State fiscal year and the total projected funding available from the  
12          sources described in subsection (b) of this section.

13          The Department shall submit detailed data supporting these calculations to the Fiscal  
14 Research Division.

15          (d) If, for any fiscal year, the nonfederal share of the cost of NC Health Works cannot be  
16 fully funded through the sources described in subsection (b) of this section, then Medicaid  
17 coverage for the individuals described in G.S. 108A-54.3A(24) shall be discontinued as  
18 expeditiously as possible. Upon a determination by the Secretary that the nonfederal share of the  
19 cost of NC Health Works exceeds the funding from the sources described in subsection (b) of  
20 this section, the Secretary shall promptly do all of the following:

21          (1) Notify the Joint Legislative Oversight Committee on Medicaid and NC Health  
22          Choice, the Office of State Budget and Management, and the Fiscal Research  
23          Division of the determination and post this notice on the Department's  
24          website. The notice must include the proposed effective date of the  
25          discontinuation of coverage.

26          (2) Submit all documents to the Centers for Medicare and Medicaid Services  
27          necessary to discontinue Medicaid coverage for the individuals described in  
28          G.S. 108A-54.3A(24).

29 **"§ 108A-54.3C. NC Health Works federal financial participation.**

30          If the federal medical assistance percentage for Medicaid coverage provided to the  
31 individuals described in G.S. 108A-54.3A(24) falls below ninety percent (90%), then Medicaid  
32 coverage for these individuals shall be discontinued as expeditiously as possible but no earlier  
33 than the date the lower federal medical assistance percentage takes effect. Upon receipt of  
34 information indicating that the federal medical assistance percentage will be lower than ninety  
35 percent (90%), the Secretary shall promptly do all of the following:

36          (1) Notify the Joint Legislative Oversight Committee on Medicaid and NC Health  
37          Choice, the Office of State Budget and Management, and the Fiscal Research  
38          Division of the determination and post this notice on the Department's  
39          website. The notice must include the proposed effective date of the  
40          discontinuation of coverage.

41          (2) Submit all documents to the Centers for Medicare and Medicaid Services  
42          necessary to discontinue Medicaid coverage for the individuals described in  
43          G.S. 108A-54.3A(24)."

44          **SECTION 1.2.(b)** This section is effective July 1, 2023, or on the date that the work  
45 requirements developed under Part II of this act become effective, whichever is earlier.

46  
47 **ARPA TEMPORARY SAVINGS FUND**

48          **SECTION 1.3.** The ARPA Temporary Savings Fund is established as a nonreverting  
49 special fund in the Department of Health and Human Services, Division of Health Benefits  
50 (DHB). The ARPA Temporary Savings Fund shall consist of any savings realized by DHB as a  
51 result of federal receipts arising from the enhanced federal medical assistance percentage

1 (FMAP) available to the State under section 9814 of the American Rescue Plan Act of 2021, P.L.  
2 117-2 (ARPA). Upon receipt by DHB of any federal receipts arising from that enhanced FMAP,  
3 DHB is directed to deposit the savings associated with those receipts into the ARPA Temporary  
4 Savings Fund. Funds in the ARPA Temporary Savings Fund may be allocated or expended only  
5 upon an act of appropriation by the General Assembly.  
6

## 7 **HOSPITAL HEALTH ADVANCEMENT ASSESSMENTS**

8 **SECTION 1.5.(a)** Each hospital licensed in North Carolina, except for critical access  
9 hospitals and State-owned and State-operated hospitals, is subject to an assessment of forty-four  
10 thousandths percent (0.044%) of its hospital costs, as defined in G.S. 108A-145.3, for the State  
11 fiscal quarter beginning October 1, 2022. This hospital assessment shall be imposed by the  
12 Department of Health and Human Services in accordance with the procedures for hospital  
13 assessments under Part 1 of Article 7B of Chapter 108A of the General Statutes. From the  
14 proceeds of this assessment, the Department of Health and Human Services shall use the sum of  
15 two million dollars (\$2,000,000), and all corresponding matching federal funds, to reimburse  
16 county departments of social services for additional costs incurred by the county in preparation  
17 to implement Section 1.1 of this act.

18 **SECTION 1.5.(b)** Subsection (a) of this section becomes effective October 1, 2022,  
19 and expires December 31, 2022.

20 **SECTION 1.5.(c)** Each hospital licensed in North Carolina, except for critical access  
21 hospitals and State-owned and State-operated hospitals, is subject to an assessment of five  
22 hundred thirty-nine thousandths percent (0.539%) of its hospital costs, as defined in  
23 G.S. 108A-145.3, for the State fiscal quarter beginning January 1, 2023, and the State fiscal  
24 quarter beginning April 1, 2023. This hospital assessment shall be imposed by the Department  
25 of Health and Human Services (DHHS) in accordance with the procedures for hospital  
26 assessments under Part 1 of Article 7B of Chapter 108A of the General Statutes. From the  
27 proceeds of this assessment, DHHS shall use the sum of two million dollars (\$2,000,000) per  
28 applicable quarter, and all corresponding matching federal funds, to reimburse county  
29 departments of social services for additional costs incurred by the county to implement Section  
30 1.1 of this act.

31 **SECTION 1.5.(d)** Subsection (c) of this section becomes effective on the effective  
32 date of the Medicaid coverage described in Section 1.1 of this act and expires June 30, 2023. If  
33 the effective date occurs after March 31, 2023, then no assessment shall be imposed for the State  
34 fiscal quarter beginning January 1, 2023, and no payments shall be made to the county  
35 departments of social services for that quarter. If the effective date occurs after June 30, 2023,  
36 then no assessment shall be imposed under subsection (c) of this section, and no payments shall  
37 be made to the county departments of social services under subsection (c) of this section.

38 **SECTION 1.6.(a)** G.S. 108A-145.3 reads as rewritten:

### 39 **"§ 108A-145.3. Definitions.**

40 The following definitions apply in this Article:

41 ...

42 (4a) Consumer Price Index. – The most recent Consumer Price Index for All Urban  
43 Consumers for the South Region published by the Bureau of Labor Statistics  
44 of the United States Department of Labor available on March 1 of the previous  
45 State fiscal year.

46 ...

47 (12b) Newly eligible individual. – As defined in 42 C.F.R. § 433.204.

48 (12c) Nonfederal share for newly eligible individuals. – One minus the percentage  
49 specified in 42 U.S.C. § 1396d(y)(1), expressed as a decimal.

50 ...."

1           **SECTION 1.6.(b)** Article 7B of Chapter 108A of the General Statutes, as enacted  
2 by Section 2 of S.L. 2021-61, is amended by adding a new Part to read:

3           "Part 3. Hospital Health Advancement Assessment.

4           "§ 108A-147.1. Hospital health advancement assessment.

5           (a)    The hospital health advancement assessment imposed under this Part shall apply to  
6 all hospitals licensed in North Carolina, except that all of the following hospitals are exempt:

7                   (1)    Critical access hospitals.

8                   (2)    State-owned and State-operated hospitals.

9           (b)    The hospital health advancement assessment shall be assessed as a percentage of each  
10 nonexempt hospital's hospital costs. The assessment percentage shall be calculated quarterly by  
11 the Department of Health and Human Services in accordance with this Part. The percentage for  
12 each quarter shall equal the hospital health advancement assessment collection amount under  
13 G.S. 108A-147.3 divided by the total hospital costs for all nonexempt hospitals holding a license  
14 on the first day of the assessment quarter.

15           "§ 108A-147.3. Hospital health advancement assessment collection amount.

16           The hospital health advancement assessment collection amount is an amount of money that  
17 is calculated by adding all of the following:

18                   (1)    The service cost component under G.S. 108A-147.5.

19                   (2)    The administration component under G.S. 108A-147.7.

20                   (3)    The State retention component under G.S. 108A-147.9.

21           "§ 108A-147.5. Service cost component.

22           The service cost component is an amount of money that is the net service expenditures  
23 calculated under this section multiplied by the nonfederal share for newly eligible individuals.  
24 Net service expenditures are calculated from the data reported to CMS on Form CMS-64 for the  
25 preceding quarter. Net service expenditures are the service expenditures attributable to newly  
26 eligible individuals after subtracting each of the following:

27                   (1)    The rebates attributable to newly eligible individuals.

28                   (2)    The expenditures under the graduate medical education methodology in the  
29 Medicaid State Plan that are attributable to newly eligible individuals.

30           "§ 108A-147.7. Administration component.

31           (a)    The administration component is an amount of money that consists of a State  
32 administration subcomponent and a county administration subcomponent.

33           (b)    The State administration subcomponent is three million three hundred thousand  
34 dollars (\$3,300,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent  
35 State fiscal year, the State administration subcomponent shall be increased over the prior year's  
36 quarterly amount by the Consumer Price Index.

37           (c)    The county administration subcomponent is two million dollars (\$2,000,000) for each  
38 quarter of the 2023-2024 State fiscal year, three million seven hundred thousand dollars  
39 (\$3,700,000) for each quarter of the 2024-2025 State fiscal year, and three million nine hundred  
40 thousand dollars (\$3,900,000) for each quarter of the 2025-2026 State fiscal year. For each State  
41 fiscal year after the 2025-2026 State fiscal year, the county administration subcomponent shall  
42 be increased over the prior year's quarterly amount by the Consumer Price Index.

43           (d)    The administration component is calculated by adding together the State  
44 administration subcomponent and the county administration subcomponent.

45           "§ 108A-147.9. State retention component.

46           The State retention component is thirty-seven million five hundred thousand dollars  
47 (\$37,500,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State  
48 fiscal year, the State retention component shall be increased over the prior year's quarterly  
49 amount by the market basket percentage.

50           "§ 108A-147.11. Use of funds.

1        The Department shall use the proceeds of the hospital health advancement assessment that  
2 are attributable to the county administration subcomponent of the administration component in  
3 G.S. 108A-147.7, and all corresponding matching federal funds, to reimburse county  
4 departments of social services for additional costs incurred by the county in determining  
5 eligibility for newly eligible individuals."

6        **SECTION 1.6.(c)** Notwithstanding G.S. 108A-147.1, as enacted in subsection (b) of  
7 this section, for the assessment quarter beginning July 1, 2023, the hospital health advancement  
8 assessment shall be five hundred fifty-five thousandths percent (0.555%) of total hospital costs  
9 for all hospitals that are not exempt from the hospital health advancement assessment.

10        **SECTION 1.6.(d)** Notwithstanding G.S. 108A-147.1, as enacted in subsection (b)  
11 of this section, for the assessment quarter beginning October 1, 2023, the Department of Health  
12 and Human Services shall determine the hospital health advancement assessment percentage by,  
13 first, either increasing or reducing the hospital health advancement assessment collection amount  
14 under G.S. 108A-147.3 by the reconciliation component under subsection (e) of this section and  
15 then dividing by the total hospital costs of all hospitals that are not exempt from the hospital  
16 health advancement assessment.

17        **SECTION 1.6.(e)** The reconciliation component is a positive or a negative number  
18 that results from subtracting ninety-three million eight hundred twenty-four thousand dollars  
19 (\$93,824,000) from the actual amount of the service cost component under G.S. 108A-147.5 for  
20 the assessment quarter beginning July 1, 2023. If the reconciliation component is a positive  
21 number, then the hospital health advancement assessment collection amount shall be increased  
22 by the reconciliation component in accordance with this section. If the reconciliation component  
23 is a negative number, then the hospital health advancement assessment collection amount shall  
24 be reduced by the reconciliation component in accordance with this section.

25        **SECTION 1.6.(f)** This section becomes effective July 1, 2023.

26        **SECTION 1.7.(a)** G.S. 108A-145.3(16) reads as rewritten:

27        "(16) Paid capitation. – The total amount of the capitation payments made by the  
28 Department to all prepaid health plans for a particular rating group (i)  
29 attributable to the base capitation rate in the applicable Medicaid managed  
30 care capitation rate ~~certification and certification~~, (ii) not attributable to newly  
31 eligible individuals, and (iii) adjusted by the Department as a result of  
32 retroactively implementing any base capitation rate adjustment that is  
33 approved by CMS or allowed under Part 438 of Subchapter C of Chapter IV  
34 of Title 42 of the Code of Federal Regulations."

35        **SECTION 1.7.(b)** G.S. 108A-146.9(a) reads as rewritten:

36        "(a) The fee-for-service component is an amount of money that is a portion of all the  
37 Medicaid fee-for-service payments made to acute care hospitals during the previous data  
38 collection period for claims with a date of service on or after July 1, ~~2021-2021~~, excluding claims  
39 attributable to newly eligible individuals. The fee-for-service component consists of a  
40 subcomponent pertaining to claims for which there is no third-party coverage and a  
41 subcomponent pertaining to claims for which there is third-party coverage."

42        **SECTION 1.7.(c)** G.S. 108A-146.12 reads as rewritten:

43        **§ 108A-146.12. Postpartum coverage component.**

44        (a) The postpartum coverage component is twelve million five hundred thousand dollars  
45 (\$12,500,000) for each quarter of the 2021-2022 State fiscal year.

46        (b) The postpartum coverage component is four million five hundred thousand dollars  
47 (\$4,500,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal  
48 year, the postpartum coverage component shall be increased over the prior year's quarterly  
49 amount by the Medicare Economic Index."

50        **SECTION 1.7.(d)** G.S. 108A-146.13(a)(2) reads as rewritten:

"(2) The postpartum subcomponent applies to the assessments under this Part only during the period of April 1, 2022, through March 31, 2027, and is two million nine hundred sixty-two thousand five hundred dollars (\$2,962,500) for each quarter of the 2021-2022 State fiscal year. For each quarter of the 2023-2024 State fiscal year, the postpartum subcomponent is one million sixty-five thousand dollars (\$1,065,000). For each subsequent State fiscal year, the postpartum subcomponent shall be increased over the prior year's quarterly amount by the Medicare Economic Index."

**SECTION 1.7.(e)** Section 9D.13A(e) of S.L. 2021-180 is repealed.

**SECTION 1.7.(f)** Section 9D.14 of S.L. 2021-180 is repealed.

**SECTION 1.7.(g)** This section becomes effective July 1, 2023.

**SECTION 1.8.** It is the intent of the General Assembly to consult with stakeholders and the Division of Health Benefits of the Department of Health and Human Services prior to its 2023 Regular Session in order to consider any necessary refinements to the hospital health advancement assessment enacted by Section 1.6 of this act.

## **HEALTHCARE ACCESS AND STABILIZATION PROGRAM**

**SECTION 1.10.(a)** The Department of Health and Human Services (DHHS) shall consult with stakeholders to develop a submission to the Centers for Medicare and Medicaid Services (CMS) to request approval for increased Medicaid reimbursements to hospitals. The nonfederal share of the requested increased Medicaid reimbursements shall be funded entirely from increased hospital assessment receipts. The submission shall request the highest increase in reimbursement to hospitals that can be funded entirely through increased hospital assessment receipts that are in addition to the receipts for NC Health Works resulting from the approach taken in the Hospital Health Advancement Assessment in this Part.

**SECTION 1.10.(b)** DHHS shall submit the request developed under subsection (a) of this section to CMS no later than October 1, 2022. If CMS does not approve the initial submission, DHHS shall continue to work with stakeholders to develop a submission that meets requirements for approval by CMS. In the event of an approval by CMS, the increased Medicaid reimbursement to hospitals shall not be effective until the enactment by the General Assembly of legislation that increases the hospital assessment to entirely fund the nonfederal share of the increased reimbursements to hospitals.

**SECTION 1.10.(c)** No later than February 1, 2023, DHHS shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division with all of the following information:

- (1) A copy of the submission to CMS made in accordance with subsection (a) of this section.
- (2) A description of the status of the approval of the submission.
- (3) Proposed legislative language authorizing the increase in the hospital assessment necessary to effectuate the increased reimbursement to hospitals.

If DHHS receives approval from CMS of any submission under this section after submitting this report, DHHS shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division of that approval within 14 days of receipt. Within 30 days of receipt of that approval, DHHS shall update and resubmit the report required by this subsection.

## **PART II. WORK REQUIREMENTS FOR CERTAIN NC HEALTH WORKS BENEFICIARIES**

### **ESTABLISH WORK REQUIREMENTS FOR CERTAIN NC HEALTH WORKS BENEFICIARIES**

1           **SECTION 2.(a)** It is the intent of the General Assembly that certain individuals  
2 eligible for Medicaid under G.S. 108A-54.3A(24), as enacted by Section 1.1 of this act, shall be  
3 subject to work requirements as a contingency to participation in NC Health Works. To this end,  
4 the Department of Health and Human Services (DHHS) shall develop work requirements as a  
5 contingency to participation in NC Health Works that are aligned with the work requirements for  
6 Able-Bodied Adults Without Dependents (ABAWDs) policy under the Supplemental Nutrition  
7 Assistance Program. All recipients qualifying under G.S. 108A-54.3A(24) shall be subject to the  
8 work requirements, except that only the following individuals shall be exempt from the  
9 requirements:

- 10           (1) Individuals who have been certified as unfit for employment for physical or  
11           mental health reasons.
- 12           (2) Individuals with a physical, intellectual, or developmental disability that  
13           significantly impairs the individual's ability to perform one or more activities  
14           of daily living.
- 15           (3) Individuals actively participating in a substance abuse treatment and  
16           rehabilitation program.
- 17           (4) Individuals who are the parent or caretaker of a dependent child under 1 year  
18           of age.
- 19           (5) Individuals who are a parent or caretaker that provides care for a dependent  
20           child with a serious medical condition or disability, to be defined by DHHS.
- 21           (6) Individuals who are receiving unemployment compensation and complying  
22           with the work requirements that are part of the federal-State unemployment  
23           compensation system.
- 24           (7) Presumptively eligible recipients, during the period of presumptive eligibility.
- 25           (8) Recipients who participate in the North Carolina Health Insurance Premium  
26           Payment (NC HIPP) program.
- 27           (9) Individuals who are inmates of prisons.

28           **SECTION 2.(b)** No later than 30 days after the effective date of this act, DHHS shall  
29 submit to the Centers for Medicare and Medicaid (CMS) any waiver necessary to implement the  
30 work requirements developed and that are intended to be a contingency for participation in NC  
31 Health Works under G.S. 108A-54.3A(24), as enacted by Section 1.1 of this act. DHHS shall  
32 request an effective date that is no later than six months from the effective date of this act. In the  
33 event that the initial submission is denied, DHHS shall continue to monitor developments on the  
34 federal level with regards to the imposition of work requirements as a contingency to eligibility  
35 for Medicaid coverage and resubmit the waiver if there are new developments. Nothing in this  
36 section shall preclude the pursuit of any legal action by the State related to federal approval or  
37 disapproval of implementation of this section.

38           **SECTION 2.(c)** This Part is effective when it becomes law. The work requirements  
39 developed under this Part shall become effective only upon the approval by CMS of the request  
40 submitted in accordance with this Part and on either (i) the effective date of the approved work  
41 requirements or (ii) six months after the date this act becomes effective, whichever is later. Upon  
42 receipt of the approval of the request required by this Part, the Secretary of the Department of  
43 Health and Human Services shall notify the Revisor of Statutes of the effective date of the work  
44 requirements approved in the request.

### 45           **PART III. CERTIFICATE OF NEED REFORM**

46           **SECTION 3.1.** G.S. 131E-176 reads as rewritten:

47           **"§ 131E-176. Definitions.**

48           The following definitions apply in this Article:

49           ...

- 1 (7b) Expedited review. – The status given to an application's review process when  
2 the applicant petitions for the review and the Department approves the request  
3 based on findings that all of the following are met:  
4 a. The review is not competitive.  
5 b. The proposed capital expenditure is less than five million dollars  
6 (\$5,000,000).  
7 ~~e. A request for a public hearing is not received within the time frame~~  
8 ~~defined in G.S. 131E-185.~~  
9 d. The agency has not determined that a public hearing is in the public  
10 interest.  
11 ...  
12 (9b) Health service facility. – A hospital; long-term care hospital; psychiatric  
13 facility; rehabilitation facility; nursing home facility; adult care home; kidney  
14 disease treatment center, including freestanding hemodialysis units;  
15 intermediate care facility for individuals with intellectual disabilities; home  
16 health agency office; ~~chemical dependency treatment facility;~~ diagnostic  
17 center; ~~hospice office, office;~~ hospice inpatient ~~facility, facility;~~ and hospice  
18 residential care ~~facility; and ambulatory surgical facility.~~  
19 (9c) Health service facility bed. – A bed licensed for use in a health service facility  
20 in the categories of (i) acute care beds; (ii) ~~psychiatric beds;~~ (iii) rehabilitation  
21 beds; ~~(iv)–(iii)~~ nursing home beds; ~~(v)–(iv)~~ intermediate care beds for  
22 individuals with intellectual disabilities; ~~(vi)–chemical dependency treatment~~  
23 ~~beds;~~ ~~(vii)–(v)~~ hospice inpatient facility beds; ~~(viii)–(vi)~~ hospice residential care  
24 facility beds; ~~(ix)–(vii)~~ adult care home beds; and ~~(x)–(viii)~~ long-term care  
25 hospital beds.  
26 ...  
27 (16) New institutional health services. – Any of the following:  
28 ...  
29 f1. The acquisition by purchase, donation, lease, transfer, or comparable  
30 arrangement of any of the following equipment by or on behalf of any  
31 person:  
32 1. Air ambulance.  
33 2. Repealed by Session Laws 2005-325, s. 1, effective for  
34 hospices and hospice offices December 31, 2005.  
35 3. Cardiac catheterization equipment.  
36 4. Gamma knife.  
37 5. Heart-lung bypass machine.  
38 5a. Linear accelerator.  
39 6. Lithotripter.  
40 7. ~~Magnetic resonance imaging scanner.~~  
41 8. Positron emission tomography scanner.  
42 9. Simulator.  
43 ...  
44 ~~f. The conversion of a specialty ambulatory surgical program to a~~  
45 ~~multispecialty ambulatory surgical program or the addition of a~~  
46 ~~specialty to a specialty ambulatory surgical program.~~  
47 ...  
48 (22a) Related entity. – A legal entity that is directly or indirectly related to an  
49 applicant for a certificate of need by any level of common ownership, control,  
50 or governance without regard to the extent, scope, size, or overlap of such  
51 common ownership, control, or governance.



(22b) Replacement equipment. – Equipment that costs less than ~~two~~four million dollars ~~(\$2,000,000)–(\$4,000,000)~~ and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than ~~two~~four million dollars ~~(\$2,000,000),~~ (\$4,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the replacement equipment cost threshold specified in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

...."

**SECTION 3.2.** G.S. 131E-178(a) reads as rewritten:

"(a) 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 gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms 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 gastrointestinal endoscopy rooms, provided that:~~Department.

- (1) ~~The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;~~
- (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; and~~
- (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 gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved."~~

**SECTION 3.3.** G.S. 131E-182(a) reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that only applications for similar proposals in the same service area that are subject to the determinative limitations of need in the State Medical Facilities Plan pursuant to subdivision (1) of subsection (a) of G.S. 131E-183 will be reviewed together."

**SECTION 3.4.(a)** G.S. 131E-183 reads as rewritten:

"§ 131E-183. Review criteria.

1 (a) The Department shall review all applications utilizing the criteria outlined in this  
 2 subsection and shall determine that an application is either consistent with or not in conflict with  
 3 these criteria before a certificate of need for the proposed project shall be issued.

4 (1) ~~The proposed projects~~ Proposed projects for air ambulances, emergency  
 5 rooms, adult care homes, adult care home beds, nursing home facilities,  
 6 nursing home beds, intermediate care facilities for individuals with  
 7 intellectual disabilities, intermediate care beds for individuals with intellectual  
 8 disabilities, home health agencies, home health agency offices, hospice  
 9 offices, hospice inpatient facilities, hospice inpatient facility beds, hospice  
 10 residential care facilities, hospice residential care facility beds, linear  
 11 accelerators, gamma knives, positron emission tomography scanners, or any  
 12 combination of these shall be consistent with applicable policies and need  
 13 determinations in the State Medical Facilities Plan, the need determination of  
 14 which constitutes a determinative limitation on the provision of any health  
 15 service, ~~health service facility, health service facility beds, dialysis stations,~~  
 16 ~~operating rooms, or home health offices~~ such services that may be approved.  
 17 All other projects are exempt from and not subject to any applicable policies  
 18 or need determinations in the State Medical Facilities Plan.

19 ...  
 20 (3) The applicant shall identify the population to be served by the proposed  
 21 project, and shall demonstrate ~~the need that this population has for the services~~  
 22 ~~proposed, and~~ the extent to which all residents of the area, and, in particular,  
 23 low income persons, racial and ethnic minorities, women, handicapped  
 24 persons, the elderly, and other underserved groups are likely to have access to  
 25 the services proposed.

26 (3a) In the case of a reduction or elimination of a service, including the relocation  
 27 of a facility or a service, the applicant shall demonstrate ~~that the needs of the~~  
 28 ~~population presently served will be met adequately by the proposed relocation~~  
 29 ~~or by alternative arrangements, and~~ the effect of the reduction, elimination or  
 30 relocation of the service on the ability of low income persons, racial and ethnic  
 31 minorities, women, handicapped persons, and other underserved groups and  
 32 the elderly to obtain needed health care.

33 ...  
 34 (6) ~~The applicant shall demonstrate that the proposed project will not result in~~  
 35 ~~unnecessary duplication of existing or approved health service capabilities or~~  
 36 ~~facilities.~~

37 ...  
 38 (9) ~~An applicant proposing to provide a substantial portion of the project's~~  
 39 ~~services to individuals not residing in the health service area in which the~~  
 40 ~~project is located, or in adjacent health service areas, shall document the~~  
 41 ~~special needs and circumstances that warrant service to these individuals.~~

42 ...  
 43 (13) The applicant shall demonstrate the contribution of the proposed service in  
 44 meeting the health-related needs of the elderly and of members of medically  
 45 underserved groups, such as medically indigent or low income persons,  
 46 Medicaid and Medicare recipients, racial and ethnic minorities, women, and  
 47 handicapped persons, which have traditionally experienced difficulties in  
 48 obtaining equal access to the proposed services, particularly those needs  
 49 identified in the State Health Plan as deserving of priority. For the purpose of  
 50 determining the extent to which the proposed service will be accessible, the  
 51 applicant shall ~~show:~~ show all of the following:

- 1 a. The extent to which medically underserved populations currently use
- 2 the applicant's existing services in comparison to the percentage of the
- 3 population in the applicant's service area which is medically
- 4 ~~underserved;underserved.~~
- 5 b. Its past performance in meeting its obligation, if any, under any
- 6 applicable regulations requiring provision of uncompensated care,
- 7 community service, or access by minorities and handicapped persons
- 8 to programs receiving federal assistance, including the existence of
- 9 any civil rights access complaints against the ~~applicant;applicant.~~
- 10 c. That the elderly and the medically underserved groups identified in
- 11 this subdivision will be served by the applicant's proposed services and
- 12 the extent to which each of these groups is expected to utilize the
- 13 proposed ~~services;andservices.~~
- 14 d. That the applicant offers a range of means by which a person will have
- 15 access to its services. Examples of a range of means are outpatient
- 16 services, admission by house staff, and admission by personal
- 17 physicians.
- 18 e. The applicant's past performance in meeting projections or other
- 19 information incorporated into prior approved certificate of need
- 20 applications filed by the applicant or a related entity during the
- 21 six-year calendar period preceding an application for a proposed
- 22 project. The Department shall use this information to assess the criteria
- 23 specified in subdivision (3) of this subsection and sub-subdivision c.
- 24 of this subdivision.

25 ...

26 (20) An applicant already involved in the provision of health services shall provide

27 evidence ~~that of the quality of care the applicant has been~~ provided in the past.

28 This subdivision applies regardless of the geographical location of the

29 applicant's existing health services operations.

30 ...

31 (d) For each health service for which a certificate of need is required, the Department

32 shall adopt rules specifying the metrics and criteria that will be used to assess the quality of care

33 the applicant has provided in the past, consistent with subdivision (20) of subsection (a) of this

34 section."

35 **SECTION 3.4.(b)** By January 1, 2023, the Department shall adopt the rules required

36 by subsection (d) of G.S. 131E-183, as enacted by this act, specifying the metrics and criteria to

37 be used to assess the quality of care a certificate of need applicant has provided in the past. Any

38 applications filed with the Department prior to the effective date of these rules shall not be subject

39 to the metrics and criteria specified in said rules.

40 **SECTION 3.5.** G.S. 131E-184 reads as rewritten:

41 "**§ 131E-184. Exemptions from review.**

42 ...

43 (c) The Department shall exempt from certificate of need review any conversion of

44 existing acute care beds to psychiatric ~~beds provided all of the following are true:~~ beds.

45 (1) ~~The hospital proposing the conversion has executed a contract with the~~

46 ~~Department's Division of Mental Health, Developmental Disabilities, and~~

47 ~~Substance Abuse Services, one or more of the area mental health,~~

48 ~~developmental disabilities, and substance abuse authorities, or a combination~~

49 ~~thereof to provide psychiatric beds to patients referred by the contracting~~

50 ~~agency or agencies.~~

1           (2)    ~~The total number of beds to be converted shall not be more than twice the~~  
2                   ~~number of beds for which the contract pursuant to subdivision (1) of this~~  
3                   ~~subsection shall provide.~~

4           (d)    ~~In accordance with, and subject to the limitations of G.S. 148-19.1, the Department~~  
5           ~~shall exempt from certificate of need review the construction and operation of a new chemical~~  
6           ~~dependency or substance abuse facility for the purpose of providing inpatient chemical~~  
7           ~~dependency or substance abuse services solely to inmates of the Division of Adult Correction~~  
8           ~~and Juvenile Justice of the Department of Public Safety. If an inpatient chemical dependency or~~  
9           ~~substance abuse facility provides services both to inmates of the Division of Adult Correction~~  
10           ~~and Juvenile Justice of the Department of Public Safety and to members of the general public,~~  
11           ~~only the portion of the facility that serves inmates shall be exempt from certificate of need review.~~

12           (e)    The Department shall exempt from certificate of need review a capital expenditure  
13           that exceeds the ~~two million dollar (\$2,000,000)~~ monetary threshold set forth in  
14           G.S. 131E-176(16)b. if all of the following conditions are met:

15           (1)    The proposed capital expenditure would meet all of the following  
16           requirements:

17           a.    Be used solely for the purpose of renovating, replacing on the same  
18           site, or expanding any of the following existing facilities:

- 19                   1.    Nursing home facility.
- 20                   2.    Adult care home facility.
- 21                   3.    Intermediate care facility for individuals with intellectual  
22                   disabilities.

23           b.    Not result in a change in bed capacity, as defined in G.S. 131E-176(5),  
24           or the addition of a health service facility or any other new institutional  
25           health service other than that allowed in G.S. 131E-176(16)b.

26           (2)    The entity proposing to incur the capital expenditure provides prior written  
27           notice to the Department, which notice includes documentation that  
28           demonstrates that the proposed capital expenditure would be used for one or  
29           more of the following purposes:

- 30                   a.    Conversion of semiprivate resident rooms to private rooms.
- 31                   b.    Providing innovative, homelike residential dining spaces, such as  
32                   cafes, kitchenettes, or private dining areas to accommodate residents  
33                   and their families or visitors.
- 34                   c.    Renovating, replacing, or expanding residential living or common  
35                   areas to improve the quality of life of residents.

36           (f)    The Department shall exempt from certificate of need review the purchase of any  
37           replacement equipment that exceeds the ~~two million dollar (\$2,000,000)~~ monetary threshold set  
38           forth in G.S. 131E-176(22a) if all of the following conditions are met:

39           (1)    The equipment being replaced is located on the main campus.

40           (2)    The Department has previously issued a certificate of need for the equipment  
41           being replaced. This subdivision does not apply if a certificate of need was not  
42           required at the time the equipment being replaced was initially purchased by  
43           the licensed health service facility.

44           (3)    The licensed health service facility proposing to purchase the replacement  
45           equipment shall provide prior written notice to the Department, along with  
46           supporting documentation to demonstrate that it meets the exemption criteria  
47           of this subsection.

48           (g)    The Department shall exempt from certificate of need review any capital expenditure  
49           that exceeds the ~~two million dollar (\$2,000,000)~~ monetary threshold set forth in  
50           G.S. 131E-176(16)b. if all of the following conditions are met:

- 1 (1) The sole purpose of the capital expenditure is to renovate, replace on the same
- 2 site, or expand the entirety or a portion of an existing health service facility
- 3 that is located on the main campus.
- 4 (2) The capital expenditure does not result in (i) a change in bed capacity as
- 5 defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or
- 6 any other new institutional health service other than that allowed in
- 7 G.S. 131E-176(16)b.
- 8 (3) The licensed health service facility proposing to incur the capital expenditure
- 9 shall provide prior written notice to the Department, along with supporting
- 10 documentation to demonstrate that it meets the exemption criteria of this
- 11 subsection.

12 ...  
 13 (i) The Department shall exempt from certificate of need review the replacement,  
 14 renovation, or relocation of an institutional health service or a health service facility for which a  
 15 certificate of need has already been issued, provided that the replacement, renovation, or  
 16 relocation of the institutional health service or health service facility is to another site within the  
 17 same service area.

18 (j) The Department shall exempt from certificate of need review the development,  
 19 acquisition, construction, expansion, or replacement of a health service facility that obtained  
 20 certificate of need approval prior to October 1, 2022, as a chemical dependency treatment facility  
 21 or an ambulatory surgical facility."

22 **SECTION 3.6.** G.S. 131E-185 reads as rewritten:

23 **"§ 131E-185. Review process.**

24 (a) Repealed by Session Laws 1987, c. 511, s. 1.

25 (a1) Except as provided in subsection (c) of this section, there shall be a time limit of 90  
 26 days for review of the applications, beginning on the day established by rule as the day on which  
 27 applications for the particular service in the service area shall begin review.

- 28 (1) ~~Any person may file written comments and exhibits concerning a proposal~~
- 29 ~~under review with the Department, not later than 30 days after the date on~~
- 30 ~~which the application begins review. These written comments may include:~~
  - 31 a. ~~Facts relating to the service area proposed in the application;~~
  - 32 b. ~~Facts relating to the representations made by the applicant in its~~
  - 33 ~~application, and its ability to perform or fulfill the representations~~
  - 34 ~~made;~~
  - 35 e. ~~Discussion and argument regarding whether, in light of the material~~
  - 36 ~~contained in the application and other relevant factual material, the~~
  - 37 ~~application complies with relevant review criteria, plans, and~~
  - 38 ~~standards.~~

- 39 (2) ~~No more than 20 days from the conclusion of the written comment period, the~~
- 40 ~~The Department shall ensure that a public hearing is conducted within the~~
- 41 ~~45-day period after the date on which the application begins review upon a~~
- 42 ~~determination by the agency that a hearing is in the public interest. The public~~
- 43 ~~hearing shall be conducted at a place within the appropriate service area ~~if one~~~~
- 44 ~~or more of the following circumstances apply; the review to be conducted is~~
- 45 ~~competitive; the proponent proposes to spend five million dollars~~
- 46 ~~(\$5,000,000) or more; a written request for a public hearing is received before~~
- 47 ~~the end of the written comment period from an affected party as defined in~~
- 48 ~~G.S. 131E 188(c); or the agency determines that a hearing is in the public~~
- 49 ~~interest. area. At such public hearing oral arguments may be made regarding~~
- 50 ~~the application or applications under review; and this public hearing shall~~
- 51 ~~include the following:~~

- 1 a. An opportunity for the proponent of each application under review to  
 2 ~~respond to the written comments submitted to the Department about~~  
 3 ~~its application;~~comment on the applications under review.  
 4 b. An opportunity for any person, except one of the proponents, to  
 5 comment on the applications under ~~review;~~review.  
 6 c. An opportunity for a representative of the Department, or such other  
 7 person or persons who are designated by the Department to conduct  
 8 the hearing, to question each proponent of applications under review  
 9 with regard to the contents of the ~~application;~~application.

10 The Department shall maintain a recording of any required public hearing  
 11 on an application until such time as the Department's final decision is issued,  
 12 or until a final agency decision is issued pursuant to a contested case hearing,  
 13 whichever is later; and any person may submit a written synopsis or verbatim  
 14 statement that contains the oral presentation made at the hearing.

- 15 (3) The Department may contract or make arrangements with a person or persons  
 16 located within each service area for the conduct of such public hearings as  
 17 may be necessary. The Department shall publish, in each service area, notice  
 18 of the contracts that it executes for the conduct of those hearings.  
 19 (4) Within 15 days from the beginning of the review of an application or  
 20 applications proposing the same service within the same service area, the  
 21 Department shall publish notice of ~~the deadline for receipt of written~~  
 22 ~~comments,~~ of the time and place scheduled for the public hearing regarding  
 23 the application or applications under review, and of the name and address of  
 24 the person or agency that will preside.  
 25 (5) The Department shall maintain ~~all written comments submitted to it during~~  
 26 ~~the written comment stage and~~ any written submissions received at the public  
 27 hearing as part of the Department's file respecting each application or group  
 28 of applications under review by it. The ~~application, written comments,~~  
 29 application, written submissions received at the public hearing, and public  
 30 hearing comments, together with all documents that the Department used in  
 31 arriving at its decision, from whatever source, and any documents that reflect  
 32 or set out the Department's final analysis of the application or applications  
 33 under review, shall constitute the Department's record for the application or  
 34 applications under review.

35 (a2) When an expedited review has been approved by the Department, no public hearing  
 36 shall be held. The Department may contact the applicant and request additional or clarifying  
 37 information, amendments to, or substitutions for portions of the application. The Department  
 38 may negotiate conditions to be imposed on the certificate of need with the applicant.

39 (b) Repealed by Session Laws 1991 (Reg. Sess., 1992), c. 900, s. 137(a).

40 (c) The Department may extend the review period for a period not to exceed 60 days and  
 41 provide notice of such extension to all applicants. For expedited reviews, the Department may  
 42 extend the review period only if it has requested additional substantive information from the  
 43 applicant."

44 **SECTION 3.7.** G.S. 131E-188 reads as rewritten:

45 "**§ 131E-188. Administrative and judicial review.**

46 (a) After a decision of the Department to issue, deny or withdraw a certificate of ~~need or~~  
 47 ~~exemption or to issue a certificate of need pursuant to a settlement agreement with an applicant~~  
 48 ~~to the extent permitted by law,~~ need, any affected ~~person,~~ applicant, as defined in subsection (c)  
 49 of this section, shall be entitled to a contested case hearing under Article 3 of Chapter 150B of  
 50 the General Statutes. A petition for a contested case shall be filed within 30 days after the  
 51 Department makes its decision. When a petition is filed, the Department shall send notification

1 of the petition to the proponent of each application that was reviewed with the application for a  
2 certificate of need that is the subject of the petition. Any affected ~~person-applicant~~ shall be  
3 entitled to intervene in a contested case.

4 A contested case shall be conducted in accordance with the following timetable:

- 5 (1) An administrative law judge or a hearing officer, as appropriate, shall be  
6 assigned within 15 days after a petition is filed.
- 7 (2) The parties shall complete discovery within ~~90-60~~ days after ~~the assignment~~  
8 ~~of the administrative law judge or hearing officer.~~ a petition is filed.
- 9 (3) The hearing at which sworn testimony is taken and evidence is presented shall  
10 be held within ~~45-30~~ days after the end of the discovery ~~period.~~ period and  
11 shall not last more than five days.
- 12 (3a) No witness shall be allowed to testify as an expert witness and offer opinion  
13 testimony based on scientific, technical, or other specialized knowledge unless  
14 that witness is properly qualified by the court pursuant to G.S. 8C-1, Rule 702.
- 15 (4) The administrative law judge or hearing officer shall make a final decision  
16 within 75 days after the hearing.
- 17 (5) Repealed by Session Laws 2011-398, s. 46, as amended by Session Laws  
18 2011-326, s. 23, effective January 1, 2012, and applicable to contested cases  
19 commenced on or after that date.

20 The administrative law judge or hearing officer assigned to a case may extend the deadlines  
21 in subdivisions (2) through (4) so long as the administrative law judge or hearing officer makes  
22 a final decision in the case within 270 days after the petition is filed.

23 (a1) On or before the date of filing a petition for a contested case hearing on the approval  
24 of an applicant for a certificate of need, the petitioner shall deposit a bond with the clerk of  
25 superior court where the new institutional health service that is the subject of the petition is  
26 proposed to be located. The bond shall be secured by cash or its equivalent in an amount equal  
27 to five percent (5%) of the cost of the proposed new institutional health service that is the subject  
28 of the petition, but may not be less than five thousand dollars (\$5,000) and may not exceed fifty  
29 thousand dollars (\$50,000). A petitioner who received approval for a certificate of need and is  
30 contesting only a condition in the certificate is not required to file a bond under this subsection.

31 The applicant who received approval for the new institutional health service that is the subject  
32 of the petition may bring an action against a bond filed under this subsection in the superior court  
33 of the county where the bond was filed. ~~Upon finding that the petition for a contested case was~~  
34 ~~frivolous or filed to delay the applicant, If a petition for a contested case hearing is dismissed or~~  
35 ~~denied, or the court otherwise rules in favor of the respondent, the court may shall~~ award the  
36 applicant ~~part~~ or all of the bond filed under this subsection. At the conclusion of the contested  
37 case, if the court ~~does not find that the petition for a contested case was frivolous or filed to delay~~  
38 ~~the applicant, rules in favor of the petitioner,~~ the petitioner shall be entitled to the return of the  
39 bond deposited with the superior court upon demonstrating to the clerk of superior court where  
40 the bond was filed that the contested case hearing is concluded.

41 (b) Any affected ~~person-applicant~~ who was a party in a contested case hearing shall be  
42 entitled to judicial review of all or any portion of any final decision in the following manner. The  
43 appeal shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the  
44 appeal shall be as provided by the rules of appellate procedure. The appeal of the final decision  
45 shall be taken within 30 days ~~of the~~ after receipt of the written notice of final decision, and notice  
46 of appeal shall be filed with the Office of Administrative Hearings and served on the Department  
47 and all other affected ~~persons-applicants~~ who were parties to the contested hearing.

48 (b1) Before filing an appeal of a final decision granting a certificate of need, the affected  
49 ~~person-applicant~~ shall deposit a bond with the Clerk of the Court of Appeals. The bond  
50 requirements of this subsection shall not apply to any appeal filed by the Department.

- 1 (1) The bond shall be secured by cash or its equivalent in an amount equal to five  
2 percent (5%) of the cost of the proposed new institutional health service that  
3 is the subject of the appeal, but may not be less than five thousand dollars  
4 (\$5,000) and may not exceed fifty thousand dollars (\$50,000); provided that  
5 the applicant who received approval of the certificate of need may petition the  
6 Court of Appeals for a higher bond amount for the payment of such costs and  
7 damages as may be awarded pursuant to subdivision (2) of this subsection.  
8 This amount shall be determined by the Court in its discretion, not to exceed  
9 three hundred thousand dollars (\$300,000). A holder of a certificate of need  
10 who is appealing only a condition in the certificate is not required to file a  
11 bond under this subsection.
- 12 (2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the  
13 applicant, the court shall remand the case to the superior court of the county  
14 where a bond was filed for the contested case hearing on the certificate of  
15 need. The superior court may award the holder of the certificate of need part  
16 or all of the bond. The court shall award the holder of the certificate of need  
17 reasonable attorney fees and costs incurred in the appeal to the Court of  
18 Appeals. If the Court of Appeals does not find that the appeal was frivolous  
19 or filed to delay the applicant and does not remand the case to superior court  
20 for a possible award of all or part of the bond to the holder of the certificate  
21 of need, the person originally filing the bond shall be entitled to a return of the  
22 bond.

23 (c) ~~The term "affected persons" includes: the applicant; any individual residing within~~  
24 ~~the service area or the geographic area served or to be served by the applicant; any individual~~  
25 ~~who regularly uses health service facilities within that geographic area or the service area; any~~  
26 ~~person who provides services, similar to the services under review, to individuals residing within~~  
27 ~~the service area or the geographic area proposed to be served by the applicant; any person who,~~  
28 ~~prior to receipt by the agency of the proposal being reviewed, has provided written notice to the~~  
29 ~~agency of an intention to provide similar services in the future to individuals residing within the~~  
30 ~~service area or the geographic area to be served by the applicant; third party payers who~~  
31 ~~reimburse health service facilities for services in the service area in which the project is proposed~~  
32 ~~to be located; and any agency which establishes rates for health service facilities or HMOs~~  
33 ~~located in the service area in which the project is proposed to be located.~~The term "affected  
34 applicants" includes only those persons who submitted applications that (i) were scheduled to  
35 begin review in the same review period proposing the same new institutional health service in  
36 the same service area and (ii) were part of a competitive review involving the application that is  
37 the subject of the petition or appeal."

38 **SECTION 3.8.** G.S. 148-19.1 reads as rewritten:

39 **"§ 148-19.1. Exemption from licensure and certificate of need licensure.**

40 (a) Inpatient chemical dependency or substance abuse facilities that provide services  
41 exclusively to inmates of the Department of Adult Correction or offenders under the supervision  
42 of the Division of Community Supervision and Reentry of the Department of Adult Correction  
43 shall be exempt from licensure by the Department of Health and Human Services under Chapter  
44 122C of the General Statutes. If an inpatient chemical dependency or substance abuse facility  
45 provides services both to inmates or offenders under supervision and to members of the general  
46 public, the portion of the facility that serves inmates or offenders under supervision shall be  
47 exempt from licensure.

48 (b) ~~Any person who contracts to provide inpatient chemical dependency or substance~~  
49 ~~abuse services to inmates of the Department of Adult Correction or to offenders under the~~  
50 ~~supervision of the Division of Community Supervision and Reentry of the Department of Adult~~  
51 ~~Correction may construct and operate a new chemical dependency or substance abuse facility for~~



1 that purpose without first obtaining a certificate of need from the Department of Health and  
2 Human Services pursuant to Article 9 of Chapter 131E of the General Statutes. However, a new  
3 facility or addition developed for that purpose without a certificate of need shall not be licensed  
4 pursuant to Chapter 122C of the General Statutes and shall not admit anyone other than inmates  
5 unless the owner or operator first obtains a certificate of need."

6 **SECTION 3.9.** If any section or provision of this Part is declared unconstitutional or  
7 invalid by the courts, it does not affect the validity of this Part as a whole or any section or  
8 provision other than the part so declared to be unconstitutional or invalid.

9 **SECTION 3.10.** Section 3.4(b) of this Part is effective when it becomes law. Section  
10 3.8 of this Part becomes effective January 1, 2023. The remainder of this Part becomes effective  
11 October 1, 2022.

#### 12 **PART IV. MODERNIZING NURSING REGULATIONS**

13 **SECTION 4.1.** G.S. 90-171.20 reads as rewritten:

##### 14 **"§ 90-171.20. Definitions.**

15 As used in this Article, unless the context requires otherwise:

16 (1) Advanced assessment. – The taking by an advanced practice registered nurse  
17 of the history, physical, and psychological assessment of a patient's signs,  
18 symptoms, pathophysiologic status, and psychosocial variations in the  
19 determination of differential diagnoses and treatment.

20 (1a) Advanced practice registered nurse or APRN. – An individual licensed by the  
21 Board as an advanced practice registered nurse within one of the following  
22 four roles:

23 a. Nurse practitioner or NP.

24 b. Certified nurse midwife or CNM.

25 c. Clinical nurse specialist or CNS.

26 d. Certified registered nurse anesthetist or CRNA.

27 (1b) ~~"Board"~~ means the Board. – The North Carolina Board of Nursing.

28 (2) ~~"Health care provider"~~ means any Health care provider. – Any licensed health  
29 care professional and any agent or employee of any health care institution,  
30 health care insurer, health care professional school, or a member of any allied  
31 health profession. For purposes of this Article, a person enrolled in a program  
32 that prepares the person to be a licensed health care professional or an allied  
33 health professional shall be deemed a health care provider.

34 (3) ~~"License"~~ means a License. – A permit issued by the Board to practice nursing  
35 as an advanced practice registered nurse, as a registered nurse-nurse, or as a  
36 licensed practical nurse, including a renewal or reinstatement thereof.

37 (3a) ~~"Licensee"~~ means any Licensee. – Any person issued a license by the Board,  
38 whether the license is active or inactive, including an inactive license by  
39 means of surrender.

40 (4) "Nursing" is a Nursing. – A dynamic discipline which includes the assessing,  
41 caring, counseling, teaching, referring and implementing of prescribed  
42 treatment in the maintenance of health, prevention and management of illness,  
43 injury, disability or the achievement of a dignified death. It is ministering to;  
44 assisting; and sustained, vigilant, and continuous care of those acutely or  
45 chronically ill; supervising patients during convalescence and rehabilitation;  
46 the supportive and restorative care given to maintain the optimum health level  
47 of individuals, groups, and communities; the supervision, teaching, and  
48 evaluation of those who perform or are preparing to perform these functions;  
49 and the administration of nursing programs and nursing services. For purposes  
50 of this Article, the administration of required lethal substances or any  
51

- 1 assistance whatsoever rendered with an execution under Article 19 of Chapter  
2 15 of the General Statutes does not constitute nursing.
- 3 (5) ~~"Nursing program" means any Nursing program. – Any educational program~~  
4 in North Carolina offering to prepare persons to meet the educational  
5 requirements for licensure under this ~~Article.~~ Article as a registered nurse or a  
6 licensed practical nurse.
- 7 (6) ~~"Person" means an Person. – An individual, corporation, partnership,~~  
8 association, unit of government, or other legal entity.
- 9 (6a) Population focus. – With respect to APRN practice, includes one of the  
10 following areas of focus:
- 11 a. The family or the individual across the life span.  
12 b. Adult/gerontology.  
13 c. Neonatal.  
14 d. Pediatrics.  
15 e. Women's health or gender-related issues.  
16 f. Psychiatric mental health.
- 17 (6b) Practice of nursing as an advanced practice registered nurse or APRN. – In  
18 addition to the RN scope of practice and within the APRN role and population  
19 foci, also consists of the following six components:
- 20 a. Conducting an advanced assessment.  
21 b. Delegating and assigning therapeutic measures to assistive personnel.  
22 c. Performing other acts that require education and training consistent  
23 with professional standards and commensurate with the APRN's  
24 education, certification, demonstrated competencies, and experience.  
25 d. Complying with the requirements of this Article and rendering quality  
26 advanced nursing care.  
27 e. Recognizing limits of knowledge and experience.  
28 f. Planning for the management of situations beyond the APRN's  
29 expertise.
- 30 (6c) Practice of nursing as a certified nurse midwife or CNM. – In addition to the  
31 RN scope of practice and APRN role and population foci, also consists of the  
32 following four components:
- 33 a. The management, diagnosis, and treatment of primary sexual and  
34 reproductive health care, including primary, preconception,  
35 gynecologic/reproductive/sexual health, antepartum, intrapartum,  
36 neonatal, and post-pregnancy care.  
37 b. Ordering, performing, supervising, and interpreting diagnostic studies.  
38 c. Prescribing pharmacologic and nonpharmacologic therapies.  
39 d. Consulting with or referring to other health care providers as  
40 warranted by the needs of the patient.
- 41 (6d) Practice of nursing as a certified registered nurse anesthetist or CRNA. – In  
42 addition to the RN scope of practice and APRN role and population foci, also  
43 consists of the following three components:
- 44 a. Selecting, ordering, procuring, prescribing, and administering drugs  
45 and therapeutic devices to facilitate diagnostic, therapeutic, and  
46 surgical procedures.  
47 b. Ordering, prescribing, performing, supervising, and interpreting  
48 diagnostic studies, procedures, and interventions.  
49 c. Consulting with or referring to other health care providers as  
50 warranted by the needs of the patient.

- 1           (6e) Practice of nursing as a clinical nurse specialist or CNS. – In addition to the  
2 RN scope of practice and APRN role and population foci, also consists of the  
3 following eight components:  
4           a. The diagnosis and treatment of health and illness states.  
5           b. Disease management.  
6           c. Prescribing pharmacologic and nonpharmacologic therapies.  
7           d. Ordering, performing, supervising, and interpreting diagnostic studies.  
8           e. Preventing of illness and risk behaviors.  
9           f. Nursing care for individuals, families, and communities.  
10          g. Integrating care across the continuum to improve patient outcomes.  
11          h. Consulting with or referring to other health care providers as  
12             warranted by the needs of the patient.
- 13          (6f) Practice of nursing as a nurse practitioner or NP. – In addition to the RN scope  
14 of practice and APRN role and population foci, also consists of the following  
15 six components:  
16          a. Health promotion, disease prevention, health education, and  
17             counseling.  
18          b. Providing health assessment and screening activities.  
19          c. Diagnosing, treating, and facilitating patients' management of their  
20             acute and chronic illnesses and diseases.  
21          d. Ordering, performing, supervising, and interpreting diagnostic studies.  
22          e. Prescribing pharmacologic and nonpharmacologic therapies.  
23          f. Consulting with or referring to other health care providers as  
24             warranted by the needs of the patient.
- 25          (7) ~~The "practice of nursing by a registered nurse" consists~~ Practice of nursing by  
26 a registered nurse. – Consists of the following 10 components:  
27          a. Assessing the patient's physical and mental health, including the  
28             patient's reaction to illnesses and treatment regimens.  
29          b. Recording and reporting the results of the nursing assessment.  
30          c. Planning, initiating, delivering, and evaluating appropriate nursing  
31             acts.  
32          d. Teaching, assigning, delegating to or supervising other personnel in  
33             implementing the treatment regimen.  
34          e. Collaborating with other health care providers in determining the  
35             appropriate health care for a patient ~~but, subject to the provisions of~~  
36             ~~G.S. 90-18.2, not prescribing a medical treatment regimen or making~~  
37             ~~a medical diagnosis, except under supervision of a licensed~~  
38             ~~physician-patient.~~  
39          f. Implementing the treatment and pharmaceutical regimen prescribed or  
40             ordered by any person authorized by State law to prescribe or order  
41             the regimen.  
42          g. Providing teaching and counseling about the patient's health.  
43          h. Reporting and recording the plan for care, nursing care given, and the  
44             patient's response to that care.  
45          i. Supervising, teaching, and evaluating those who perform or are  
46             preparing to perform nursing functions and administering nursing  
47             programs and nursing services.  
48          j. Providing for the maintenance of safe and effective nursing care,  
49             whether rendered directly or indirectly.

- (8) ~~The "practice of nursing by a licensed practical nurse" consists~~ Practice of nursing by a licensed practical nurse. – Consists of the following seven components:
- a. Participating in the assessment of the patient's physical and mental health, including the patient's reaction to illnesses and treatment regimens.
  - b. Recording and reporting the results of the nursing assessment.
  - c. Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks assigned or delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide the supervision.
  - c1. Assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse.
  - d. Participating in the teaching and counseling of patients as assigned by a registered nurse, physician, or other qualified professional licensed to practice in North Carolina.
  - e. Reporting and recording the nursing care rendered and the patient's response to that care.
  - f. Maintaining safe and effective nursing care, whether rendered directly or indirectly."

**SECTION 4.2.** G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in this Article:

...

~~(7) The practice of midwifery as defined in G.S. 90-178.2.~~

...

(14) ~~The practice of nursing by a~~ an advanced practice registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards as defined in Article 9A of this Chapter.

...."

**SECTION 4.3.(a)** G.S. 90-18.2 is repealed.

**SECTION 4.3.(b)** G.S. 90-2(a) reads as rewritten:

"(a) There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 13 members:

...

(2) Five members shall all be appointed by the Governor as follows:

...

d. One shall be a nurse practitioner ~~as defined in G.S. 90-18.2~~ as recommended by the Review Panel pursuant to G.S. 90-3.

...."

**SECTION 4.3.(c)** G.S. 90-18.3(a) reads as rewritten:

"(a) Whenever a statute or State agency rule requires that a medical or physical examination shall be conducted by a physician, the examination may be conducted and the form signed by a nurse practitioner or a physician assistant, and a physician need not be present.

1 Nothing in this section shall otherwise change the scope of practice of a nurse practitioner or a  
2 physician assistant, as defined by G.S. 90-18.1 and ~~G.S. 90-18.2, G.S. 90-171.20,~~ respectively."

3 **SECTION 4.3.(d)** G.S. 90-85.24(a) reads as rewritten:

4 "(a) The Board of Pharmacy shall be entitled to charge and collect not more than the  
5 following fees:

6 ...

7 (13) For annual registration as a dispensing nurse ~~practitioner under G.S. 90-18.2,~~  
8 practitioner, seventy-five dollars (\$75.00);

9 ...."

10 **SECTION 4.3.(e)** G.S. 90-85.34A reads as rewritten:

11 "**§ 90-85.34A. Public health pharmacy practice.**

12 ...

13 (c) This section does not affect the practice of nurse practitioners ~~pursuant to G.S. 90-18.2~~  
14 or of physician assistants pursuant to G.S. 90-18.1."

15 **SECTION 4.4.** G.S. 90-29(b) reads as rewritten:

16 "(b) A person shall be deemed to be practicing dentistry in this State who does, undertakes  
17 or attempts to do, or claims the ability to do any one or more of the following acts or things  
18 which, for the purposes of this Article, constitute the practice of dentistry:

19 ...

20 (6) Administers an anesthetic of any kind in the treatment of dental or oral  
21 diseases or physical conditions, or in preparation for or incident to any  
22 operation within the oral cavity; provided, however, that this subsection shall  
23 not apply to a ~~lawfully qualified certified registered nurse~~ anesthetic who  
24 administers such ~~anesthetic under the supervision and direction of a licensed~~  
25 ~~dentist or physician, anesthetic,~~ or to a registered dental hygienist qualified to  
26 administer local anesthetics.

27 ...."

28 **SECTION 4.5.** G.S. 90-171.23(b) reads as rewritten:

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

30 ...

31 (14) ~~Appoint and maintain a subcommittee of the Board to work jointly with the~~  
32 ~~subcommittee of the North Carolina Medical Board to develop rules and~~  
33 ~~regulations to govern the performance of medical acts by registered nurses~~  
34 ~~and to determine reasonable fees to accompany an application for approval or~~  
35 ~~renewal of such approval as provided in G.S. 90-8.2. The fees and rules~~  
36 ~~developed by this subcommittee shall govern the performance of medical acts~~  
37 ~~by registered nurses and shall become effective when they have been adopted~~  
38 ~~by both Boards.~~ Grant prescribing, ordering, dispensing, and furnishing  
39 authority to holders of the advanced practice registered nurse license pursuant  
40 to G.S. 90-171.20.

41 ...."

42 **SECTION 4.6.** G.S. 90-171.27(b) reads as rewritten:

43 "**§ 90-171.27. Expenses payable from fees collected by Board.**

44 ...

45 (b) The schedule of fees shall not exceed the following rates:

46	<u>Application for license as advanced practice registered nurse.....</u>	<u>\$100.00</u>
47	<u>Renewal of license to practice as advanced practice registered nurse</u>	
48	<u>(two-year period).....</u>	<u>100.00</u>
49	<u>Reinstatement of lapsed license to practice as advanced practice</u>	
50	<u>registered nurse and renewal fee.....</u>	<u>180.00</u>

1	Application for examination leading to <del>certificate and</del> license as	
2	registered nurse .....	\$75.00
3	Application for <del>certificate and</del> license as registered nurse by	
4	endorsement .....	150.00
5	Application for each re-examination leading to <del>certificate and</del> license as	
6	registered nurse .....	75.00
7	Renewal of license to practice as registered nurse (two-year period).....	100.00
8	Reinstatement of lapsed license to practice as a registered nurse and	
9	renewal fee .....	180.00
10	Application for examination leading to <del>certificate and</del> license as licensed	
11	practical nurse by examination .....	75.00
12	Application for <del>certificate and</del> license as licensed practical nurse by	
13	endorsement .....	150.00
14	Application for each re-examination leading to <del>certificate and</del> license as	
15	licensed practical nurse .....	75.00
16	Renewal of license to practice as a licensed practical nurse (two-year	
17	period) .....	100.00
18	Reinstatement of lapsed license to practice as a licensed practical nurse	
19	and renewal fee .....	180.00
20	Application fee for retired registered nurse status or retired licensed	
21	practical nurse status .....	50.00
22	Reinstatement of retired registered nurse to practice as a registered nurse	
23	or a retired licensed practical nurse to practice as a licensed	
24	practical nurse (two-year period) .....	100.00

Reasonable charge for duplication services and materials.

A fee for an item listed in this schedule shall not increase from one year to the next by more than twenty percent (20%)."

**SECTION 4.7.(a)** Article 9A of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

**"§ 90-171.36B. Advanced practice registered nurse licensure.**

(a) No advanced practice registered nurse shall practice as an advanced practice registered nurse unless the nurse is licensed by the Board under this section.

(b) An applicant for a license to practice as an APRN shall apply to the Board in a format prescribed by the Board and pay a fee in an amount determined under G.S. 90-171.27.

(c) The Board shall adopt rules, not inconsistent with this Article, which identify the criteria which must be met by an applicant in order to be issued a license.

**"§ 90-171.36C. Advanced practice registered nurse licensure; grandfathering exceptions.**

(a) The Board shall issue an APRN license to any person recognized by the Board as an APRN or approved to practice as an APRN in this State on December 31, 2021.

(b) An advanced practice registered nurse licensed under this section shall maintain all practice privileges provided to licensed advanced practice registered nurses under this Chapter.

**"§ 90-171.36D. Advanced practice registered nurse licensure renewal; reinstatement.**

(a) An applicant for renewal of an APRN license issued under this Article shall apply for licensure renewal according to the frequency and schedule established by the Board and pay the required fee.

(b) Failure to renew the APRN license before the expiration date shall result in automatic forfeiture of the right to practice nursing as an APRN in North Carolina until such time as the license has been reinstated.

(c) An APRN licensee who has allowed his or her license to lapse by failure to renew may apply for reinstatement in a manner prescribed by the Board and pay the required fee.

1 (d) The Board shall adopt rules, not inconsistent with this Article, which identify the  
 2 criteria which must be met by an applicant for APRN license renewal or reinstatement."

3 **SECTION 4.7.(b)** G.S. 90-171.37(b) is repealed.

4 **SECTION 4.8.** G.S. 90-171.43 reads as rewritten:

5 **"§ 90-171.43. License required.**

6 (a) No person shall practice or offer to practice as ~~a~~an advanced practice registered nurse,  
 7 registered nurse-nurse, or licensed practical nurse, or use the word "nurse" as a title for herself or  
 8 himself, or use an abbreviation to indicate that the person is ~~a~~an advanced practice registered  
 9 nurse, registered ~~nurse-nurse,~~ or licensed practical nurse, unless the person is currently licensed  
 10 as ~~a~~an advanced practice registered nurse, registered ~~nurse-nurse,~~ or licensed practical nurse as  
 11 provided by this Article. If the word "nurse" is part of a longer title, such as "nurse's aide", a  
 12 person who is entitled to use that title shall use the entire title and may not abbreviate the title to  
 13 "nurse". This Article shall not, however, be construed to prohibit or limit the following:

- 14 (1) The performance by any person of any act for which that person holds a  
 15 license issued pursuant to North Carolina ~~law;~~law.
- 16 (2) The clinical practice by students enrolled in approved nursing programs,  
 17 continuing education programs, or refresher courses under the supervision of  
 18 qualified ~~faculty;~~faculty.
- 19 (3) The performance of nursing performed by persons who hold a temporary  
 20 license issued pursuant to ~~G.S. 90-171.33;~~G.S. 90-171.33.
- 21 (4) The delegation to any person, including a member of the patient's family, by  
 22 a physician licensed to practice medicine in North Carolina, a licensed dentist  
 23 or registered nurse of those patient-care services which are routine, repetitive,  
 24 limited in scope that do not require the professional judgment of a registered  
 25 nurse or licensed practical ~~nurse;~~nurse.
- 26 (5) Assistance by any person in the case of emergency.

27 Any person permitted to practice nursing without a license as provided in subdivision ~~{(a)}~~(2)  
 28 (a)(2) or ~~{(a)}~~(3)-(a)(3) of this section shall be held to the same standard of care as any licensed  
 29 nurse.

30 (a1) The abbreviations for the APRN designation of a certified nurse midwife, a clinical  
 31 nurse specialist, a certified registered nurse anesthetist, and a nurse practitioner shall be APRN,  
 32 plus the role title, i.e., CNM, CNS, CRNA, and NP.

33 (a2) It shall be unlawful for any person to use the title "APRN" or "APRN" plus their  
 34 respective role titles, the role title alone, authorized abbreviations, or any other title that would  
 35 lead a person to believe the individual is an APRN, unless permitted by this act.

36 ...."

37 **SECTION 4.9.** G.S. 90-171.43A reads as rewritten:

38 **"§ 90-171.43A. Mandatory employer verification of licensure status.**

39 (a) Before hiring an advanced practice registered nurse, a registered ~~nurse-nurse,~~ or a  
 40 licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has  
 41 a current, valid license to practice nursing pursuant to G.S. 90-171.43.

42 (b) For purposes of this section, "health care facility" means:

- 43 (1) Facilities described in G.S. 131E-256(b).
- 44 (2) Public health departments, physicians' offices, ambulatory care facilities, and  
 45 rural health clinics."

46 **SECTION 4.10.** G.S. 90-171.44 reads as rewritten:

47 **"§ 90-171.44. Prohibited acts.**

48 It shall be a violation of this Article, and subject to action under G.S. 90-171.37, for any  
 49 person to:

- 50 (1) Sell, fraudulently obtain, or fraudulently furnish any nursing diploma or aid  
 51 or abet therein.

- 1 (2) Practice nursing under cover of any fraudulently obtained license.
- 2 (3) Practice nursing without a license. This subdivision shall not be construed to
- 3 prohibit any licensed registered nurse who has successfully completed a
- 4 program established under G.S. 90-171.38(b) from conducting medical
- 5 examinations or performing procedures to collect evidence from the victims
- 6 of offenses described in that subsection.
- 7 (3a) Refer to himself or herself as an advanced practice registered nurse; or refer
- 8 to himself or herself as any of the four roles of advanced practice registered
- 9 nurses, a registered nurse, or a licensed practical nurse; or use the
- 10 abbreviations "APRN," "CNM," "CNS," "CRNA," "NP," "RN," and "LPN."
- 11 (4) Conduct a nursing program or a refresher course for activation of a license,
- 12 that is not approved by the Board.
- 13 (5) Employ unlicensed persons to practice nursing."

14 **SECTION 4.11.(a)** Article 10A of Chapter 90 of the General Statutes is repealed.  
 15 **SECTION 4.11.(b)** G.S. 90-21.11 reads as rewritten:

16 **"§ 90-21.11. Definitions.**

17 The following definitions apply in this Article:

- 18 (1) Health care provider. – Without limitation, any of the following:
- 19 a. A person who pursuant to the provisions of Chapter 90 of the General
- 20 Statutes is licensed, or is otherwise registered or certified to engage in
- 21 the practice of or otherwise performs duties associated with any of the
- 22 following: medicine, surgery, dentistry, pharmacy, optometry,
- 23 ~~midwifery,~~ osteopathy, podiatry, chiropractic, radiology, nursing,
- 24 physiotherapy, pathology, anesthesiology, anesthesia, laboratory
- 25 analysis, rendering assistance to a physician, dental hygiene,
- 26 psychiatry, or psychology.

27 ...."

28 **SECTION 4.12.(a)** No later than 30 calendar days after this act becomes law, the  
 29 Governor shall submit to the Centers for Medicare and Medicaid Services an "opt-out" letter  
 30 requesting an exemption under 42 C.F.R. § 482.52(c) that allows hospitals, ambulatory surgical  
 31 centers, critical access hospitals, and rural hospitals in this State the maximum flexibility to  
 32 obtain Medicare reimbursement for anesthesia services in a manner that best serves each facility  
 33 and the patients and communities the facility serves.

34 **SECTION 4.12.(b)** This section is effective when it becomes law.

35 **SECTION 4.13.(a)** The North Carolina Board of Nursing, the North Carolina  
 36 Medical Board, and the North Carolina State Board of Dental Examiners shall adopt rules to  
 37 implement the provisions of this Part.

38 **SECTION 4.13.(b)** This section is effective when it becomes law.

39 **SECTION 4.14.** Except as otherwise provided, this Part becomes effective October  
 40 1, 2022.

41  
 42 **PART V. HEALTH INSURANCE REFORMS**

43  
 44 **MEDICAL BILLING TRANSPARENCY**

45 **SECTION 5.1.(a)** Article 3 of Chapter 58 of the General Statutes is amended by  
 46 adding a new section to read:

47 **"§ 58-3-295. Contract requirements for limitations on billing by in-network health service**  
 48 **facilities.**

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

- 50 (1) Health care provider. – Any individual licensed, registered, or certified under  
 51 Chapter 90 of the General Statutes, or under the laws of another state, to



1 provide health care services in the ordinary care of business or practice, as a  
2 profession, or in an approved education or training program in any of the  
3 following:

- 4 a. Anesthesia or anesthesiology.
- 5 b. Emergency services, as defined under G.S. 58-3-190(g).
- 6 c. Pathology.
- 7 d. Radiology.
- 8 e. Rendering assistance to a physician performing any of the services  
9 listed in this subdivision.

10 (2) Health service facility. – As defined in G.S. 131E-176(9b) and including any  
11 office location.

12 (3) Out-of-network provider. – A health care provider that has not entered into a  
13 contract or agreement with an insurer to participate in one of the insurer's  
14 provider networks for the provision of health care services at a pre-negotiated  
15 rate.

16 (b) All contracts or agreements for participation as an in-network health service facility  
17 between an insurer offering health benefit plans in this State and a health service facility at which  
18 there are out-of-network providers who may be part of the provision of services to an insured  
19 while receiving care at the health service facility shall require that the in-network health service  
20 facility give at least 72 hours' advanced written notification to an insured that has scheduled an  
21 appointment at that health service facility of the provision of any services by an out-of-network  
22 provider to the insured while at that health service facility. If there are not at least 72 hours  
23 between the scheduling of the appointment and the appointment, then the in-network health  
24 service facility is required to give written notice to the insured on the day the appointment is  
25 scheduled. In the case of emergency services, the health service facility is required to give written  
26 notice to the insured as soon as reasonably possible. The written notice required by this  
27 subsection shall include all of the following:

28 (1) All of the health care providers that will be rendering services to the insured  
29 that are not participating as in-network health care providers in the applicable  
30 insurer's network.

31 (2) The estimated cost to the insured of the services being rendered by the  
32 out-of-network providers identified in subdivision (1) of this subsection.

33 (c) If any provision of this section conflicts with the federal Consolidated Appropriations  
34 Act, 2021, P.L. 116-260, and any amendments to that act or regulations promulgated pursuant to  
35 that act, then the provisions of P.L. 116-260 will be applied."

36 **SECTION 5.1.(b)** This section becomes effective January 1, 2023, and applies to  
37 contracts entered into, amended, or renewed on or after that date.

## 38 ACCESS TO TELEHEALTH

39 **SECTION 5.2.(a)** Part 7 of Article 50 of Chapter 58 of the General Statutes is  
40 amended by adding a new section to read:

### 41 **"§ 58-50-305. Coverage for telehealth services.**

42 (a) For the purposes of this section, the following definitions apply:

43 (1) Health care provider. – As defined in G.S. 58-50-61.

44 (2) Health care services. – As defined in G.S. 58-50-61, with the exception of any  
45 services related to an abortion, including a medication abortion, except in the  
46 case of a medical emergency, as defined in G.S. 90-21.81(5).

47 (3) Reserved for future codification purposes.

48 (4) Telehealth. – As defined in G.S. 90-21.19A, except that the following shall  
49 not be considered telehealth unless specifically agreed upon, in writing, by the  
50

insurer and the health care provider or contained in reimbursement policies of the insurer for the relevant health benefit plan:

- a. Administrative functions, including, but not limited to, scheduling, billing, conducting surveys or questionnaires, providing reminders, or conveying test results.
- b. Emails, text messages, or correspondence through an online patient portal, or any combination of those, in which evaluation, management, or medical decision making by a qualified health care provider does not occur.
- c. Triage functions.
- d. Health care provider-to-health care provider consultations.
- e. Therapy, or other patient sessions, provided by unlicensed peers or health coaches.
- f. Remote patient monitoring.
- g. Audio-only formats, except as defined by audio-only service codes contained within current year American Medical Association Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code sets.
- h. Services where current technology requires hands-on physical evaluation or manipulation by a qualified health care provider, including infusions, injections, biopsies, anesthesia, incisions, and surgery, and other similar services.
- i. Facility fees or facility services.
- j. Any other function that does not involve medical decision making from a health care provider.

(b) An insurer may not exclude from coverage a health care service or procedure delivered by a health care provider to an insured through telehealth solely because the health care service or procedure is not provided through an in-person, face-to-face consultation.

(c) An insurer is not required to provide coverage for any out-of-network services provided via telehealth.

(d) An insurer may exclude from coverage a health care service delivered by a contracted, or an in-network, health care provider to an insured that is provided solely as a telehealth service without any in-person, face-to-face component if any of the following apply:

- (1) The billing code submitted to the insurer does not accurately describe the health care service for which the health care provider is billing.
- (2) The health care provider has not agreed to share claims data or clinical data through the NC Health Information Exchange, established under Article 29B of Chapter 90 of the General Statutes, or as otherwise required by the insurer.
- (3) The health care service provided is the subject of a utilization management program, or other applicable cost-containment or quality management program, of the insurer.
- (4) The health care service is not provided by the patient's designated primary care provider or designated medical home.
- (5) The health care provider has not obtained informed consent from the patient, as required under G.S. 90-21.19A.
- (6) The insurer determines that the receipt of the health care services through telehealth would impact quality of care or safety of its insureds."

**SECTION 5.2.(b)** G.S. 58-50-280 reads as rewritten:

**"§ 58-50-280. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-275. The proposed amendment

1 shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include  
2 an effective date for the proposed amendment.

3 (b) A health care provider receiving a proposed amendment shall be given at least 60  
4 days from the date of receipt to object to the proposed amendment. The proposed amendment  
5 shall be effective upon the health care provider failing to object in writing within 60 days.

6 (c) If a health care provider objects to a proposed amendment, then the ~~proposed~~  
7 ~~amendment is not effective and the initiating health benefit plan or insurer shall be provider is~~  
8 entitled to terminate the contract upon 60 days written notice to the ~~health care provider-insurer~~  
9 issuing the health benefit plan.

10 (d) Nothing in this Part prohibits a health care provider and insurer from negotiating  
11 contract terms that provide for mutual consent to an amendment, a process for reaching mutual  
12 consent, or alternative notice contacts."

13 **SECTION 5.2.(c)** Article 1B of Chapter 90 of the General Statutes is amended by  
14 adding a new section to read:

15 **"§ 90-21.19A. Telehealth consumer protections.**

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

17 (1) Health benefit plan. – As defined under G.S. 58-3-167.

18 (2) Health services facility. – As defined in G.S. 131E-176, and including any  
19 office location.

20 (3), (4) Reserved for future codification purposes.

21 (5) Telehealth. – The use of telecommunications technology to provide health  
22 care services to individuals who are not physically present with the health care  
23 provider.

24 (b) Specific informed consent shall be required when health care services are provided  
25 through telehealth to individuals who are insured under a health benefit plan. The required  
26 informed consent includes all of the following:

27 (1) Confirmation of the identity of the individual to whom the health care services  
28 are provided.

29 (2) Verification and authentication of the individual's personal health history.

30 (3) Disclosure of the health care provider's identity, applicable credentials, and  
31 contact information, including a current phone number and mailing address of  
32 the health care provider's practice.

33 (4) Disclosure of the delivery model and treatment methods to be utilized,  
34 including any limitations of the use of telehealth to provide those health care  
35 services. The health care provider is required to document an  
36 acknowledgement by the individual, or other authorized party, of the risks and  
37 limitations associated with the use of telehealth for the provision of the  
38 relevant health care services.

39 (5) Provision of informed consent that would be applicable if the delivery of the  
40 health care services were made in person.

41 (6) An explanation that it is the role of the health care provider to determine  
42 whether the condition being diagnosed or treated is appropriate for a telehealth  
43 encounter and advise the individual that the individual is entitled to request an  
44 in-person encounter in lieu of a telehealth visit.

45 (7) If applicable or required for an in-person encounter, provision of the contact  
46 information for the North Carolina Medicaid Board, or other applicable  
47 licensing board, and a description of, or a website link to, the patient complaint  
48 process for the Board.

49 (c) Prior to the provision of a health care service through telehealth, the health care  
50 provider rendering the health care service shall clearly identify all of the following:

- 1           (1)    The billing entity and the location, phone number, and regulator of the billing
- 2                    entity.
- 3           (2)    Name and location of the health care provider delivering the telehealth
- 4                    service, if different from the initial disclosure.
- 5           (3)    The service or procedure being provided.
- 6           (4)    The estimated cost of care. Estimates of the cost of care shall be based on the
- 7                    health benefit plan under which the individual is insured, if applicable.
- 8           (5)    The network status of the health care provider based on the health benefit plan
- 9                    under which the individual is insured, if applicable.

10        (d)    All health care providers rendering health care services through telehealth shall  
 11 comply with all of the following requirements:

- 12           (1)    Documentation of all informed consent shall be made in the patient's medical
- 13                    history for each telehealth service.
- 14           (2)    No fee may be applied to patients, insurers, other health care providers, or
- 15                    health care facilities for sharing patient medical records for telehealth services.
- 16                    A health care provider or health care facility shall transfer, free of charge, the
- 17                    patient's medical records to any health care provider or health care facility
- 18                    identified by the patient.
- 19           (3)    Electronic documentation and storage of patient medical records in
- 20                    accordance with all applicable State and federal privacy laws.
- 21           (4)    Creation of a saved recording of all patient telehealth encounters, in
- 22                    accordance with all applicable State and federal privacy laws.

23        (e)    Health care providers and health care facilities are prohibited from engaging in any  
 24 balancing billing related to any health care service provided through telehealth."

25            **SECTION 5.2.(d)** This section becomes effective October 1, 2022, and applies to  
 26 insurance contracts entered into, renewed, or amended on or after that date, or to health care  
 27 services provided on or after that date, as applicable.

28  
 29 **PART VI. EFFECTIVE DATE**

30            **SECTION 6.** Except as otherwise provided, this act is effective when it becomes  
 31 law.