

North Carolina Health Care Law Update – Pending Legislation

The following report examines pending legislation marked as a “High Priority” by the North Carolina Healthcare Association.

BILLS SUPPORTED BY THE NCHA

HB 184: Study State Health Plan Design

House Bill 184 would create a committee to study and report on redesigning the State Health Plan (the “Plan”) for Teachers and State Employees in a way that would adopt new practices and payment methodologies. However, it would also require that the Plan continue to adhere to the current payment schedule through December 31, 2020.

Currently, the Board of Trustees of the State Health Plan for Teachers and State Employees has the authority to set provider reimbursement rates for the Plan. Under the proposed legislation, the Bill would create the Joint Legislative Study Committee on the Sustainability of the North Carolina State Health Plan. This committee would consist of four members appointed by both the House and the Senate, as well as two members appointed by the State Employees Association of North Carolina, and one member by each of the following entities: the North Carolina Medical Society, the North Carolina Healthcare Association, the North Carolina Nurses Association, the Retired Government Employees of North Carolina, the North Carolina Association of Educators, and the North Carolina Psychiatry Association. Lastly, the Executive Administrator of the State Health Plan would be a member, and the State Treasurer would be an ex-officio, non-voting member.

The committee would have its initial meeting within 30 days of the effective date of the act and would be considering the following as a part of recommending a design for the State Health Plan:

- Pricing that is referenced to other payment models.
- Payment models that have been shown to reduce costs without compromising care.
- Methods to ensure transparency with regards to pricing and costs.
- Employee and family premiums.
- Incentive programs to encourage utilization of primary care.
- Virtual health options.
- Combining the State Health Plan with other State-funded health plans.
- Payments of subsidies for buying individual plans on the marketplace.
- Data that compares a five-year history of actual costs to the plan versus anticipated costs and spending projections.
- Claims data by health care provider claimants.
- Demographic data of Plan subscribers.
- Any other items necessary for development of a modern State Health Plan.

Ultimately, the Committee would submit a final report to the General Assembly no later than December 15, 2019 and would terminate on the later of filing its report or April 1, 2020.

Additionally, the Bill would require the State Health Plan to continue to reimburse providers according to the fee schedules that are currently in effect until December 31, 2020. The Bill would also prohibit the State Health Plan from implementing any referenced-based pricing model until December 31, 2020.

Currently, the NCHA supports the Bill and noted that the commission will help ensure future solvency of the Plan while simultaneously striving to improve the health of every plan member.

HB 555 – Modernize Medicaid Telemedicine Policies

This Bill would require the Department of Health and Human Services (DHHS) to make 6 specified changes to the Medicaid and NC Health Choice Clinical Coverage Policy No. 1H, Telemedicine and Telepsychiatry regarding: reimbursement, referrals, delivery over the phone or video cell phone, same date billing, best practices for telemedicine and telepsychiatry, and inclusion in the coverage policy of certain behavioral health providers.

In addition to changes to the Clinical Coverage Policy No. 1H, this Bill also directs DHHS to expand the billing code set available for telemedicine and telepsychiatry to include most outpatient billing codes, including family therapy and psychotherapy for crisis. With the exception of family therapy, the expanding billing codes shall not include group-type therapies. Lastly, the Bill will also require DHHS to submit to the Centers for Medicare and Medicaid Services any waivers or amendments to the NC Medicaid State Plan necessary to implement this act.

HB 562 – Health Care Reimbursement Contracts/AOBs

This Bill would amend Article 3 of Chapter 58 of the NC statutes by adding language mandating that a reimbursement contract between a health care provider and an insurer or a third-party payor shall require that reimbursement be made directly to the health care provider for any covered service provided by the health care provider under the reimbursement contract.

Additionally, the Bill would require an insurer or third party-payor to accept and honor a completed assignment of benefits agreement that assigns the insured's reimbursement benefits to a health care provider. However, this section of the Bill will only apply if there is no reimbursement contract between a health care provider and an insurer or a third-party payor. Lastly, the prompt claims payment provisions under N.C. Gen. Stat. 58-3-225 would apply to payments made under reimbursements contracts or through an assignment of benefits agreement.

BILLS OPPOSED BY THE NCHA

SB 361 – Health Care Expansion Act of 2019

Part I of this Bill would amend the North Carolina Innovations waiver to increase the number of slots available by a maximum of 1,000 slots to be made available on January 1, 2020 and by a maximum of 1,000 slots to be made available on January 1, 2021. Additionally, Part I appropriates \$10,250,000 in recurring funds for the 2019-202 fiscal year and \$30,750,000 in recurring funds for the 2020-2021 fiscal year to be used to fund these additional slots.

Part II of this Bill would repeal Article 9 of Chapter 131E of the General Statutes, 37 G.S. 130A-45.02(i), 143B-1292, 150B-2(8a)k., and 150B-21.1(6). Additionally, it would make changes to N.C. Gen. Stat. 6-19.1(a), explicitly repudiating creation of any right of action or waiver of immunity to agencies otherwise immune from suit, to N.C. Gen. Stat. 58-50-61(a) to define "health service facility" as it was defined in the repealed article, and to N.C. Gen. Stat. 58-55-35(a) to redefine "hospice" and "Intermediate care facility for individuals with intellectual disabilities" as they were defined in the repealed article.

Part III of this Bill would recodify Article 18A of Chapter 90, as Article 18G of Chapter 90, and would enact a new article, 18H, entitled the "Psychology Interjurisdictional Licensure Compact." This new section is designed to: increase public access to professional psychological services, enhance the state's ability to protect public health and safety, encourage the cooperation of other Compact States in areas of psychology, facilitate exchange of information between Compact states, promote compliance with laws in Compact states, and to increase licensed psychologist accountability.

By way of background the "Compact" language refers to sister states who have adopted similar legislation to facilitate an expedited pathway to licensure for qualified physicians who wish to practice in multiple states. Accordingly, SB 361 outlines the requirements a psychologists licensed to practice in a compact state must meet in order to practice interjurisdictional telepsychology. Similarly, SB 361 places limitations on the scope and duration of a licensed psychologists authority to practice interjurisdictional telepsychology.

Part IV of this Bill would amend N.C. Gen. Stat. 122C-263.1(a), which governs certification criteria for health professional who can perform commitment examinations for involuntary commitments, to include licensed marriage and family therapists.

Part V of this bill would amend N.C. Gen. Stat. 131E-138 to create a licensure exception for home care services provided to participants of the Program for All-Inclusive Care for the Elderly through an organization that has a valid Program for All-Inclusive Care for the Elderly agreement with the Centers for Medicare and Medicaid Services and the Divisions of health Benefits of the Department of Health and Human Services. This bill would also amend 131D-2.1 to amend the definitions of adult care home, assisted living residence, and multiunit assisted housing with service to include those residences that provide specified services with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Depart of Health and Human Services.

This Bill would amend 131D-2.2 to indicate that the resident of an assisted living facility has the right to select as the resident's health care provider the Program for All-Inclusive Care for the Elderly without jeopardizing residency in the assisted living facility.

This Bill would amend 131D-2.16 to add language requiring that the Medical Care Commission will consider, in developing rules, to consider the need to ensure comparable quality of services provided to residents whether these services are provided directly by a licensed assisted living provider, licensed home care agency, a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services, or hospice.

Lastly, this Bill would also amend 131D-6 to exempt Program for All-Inclusive Care for the Elderly organizations that have a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services to participants in the program from the certification requirements of adult day care programs.

Part VI of this bill would amend N.C. Gen. Stat. 131D-2.11 to include that if the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection unless failure to address that violation would pose a risk to resident safety.

Part VII of this Bill provides a severability clause.

SB 386 – Greater Transparency in Health Care Billing

This Bill would set out to repeal, amend, and enact various pieces of legislation with the intention of providing greater transparency in health care services billing and to reduce billing which comes as a surprise to the Patient. Specifically, this Bill would enact limitations on balance billing, enact fair notice requirements, and place restrictions on fair billing and collection practices. Failure to comply with the terms of this legislation would be deemed an unfair and deceptive trade practices act and would give rise to a private cause of action under N.C. Gen. Stat. 75.

In opposing this bill, the North Carolina Healthcare Association believes that the Bill “addresses a problem that does not exist” and is also being handled at the federal level.

SB 539 – Repeal CON Laws

This Bill would repeal North Carolina’s Certificate of Need Laws under N.C. Gen. Stat. 131E, Article 9. Generally speaking, North Carolina requires the proponent of a new institutional health service to obtain a certificate of need from the Department of Health and Human Services in order to proceed with the development of such project. In addition to repealing the certificate of need requirement, and making subsequent conforming changes to the affected statutes, this Bill would incorporate the existing definition for “health service facility,” “Hospice,” and “Intermediate care facility” from the repealed statute into N.C. Gen. Stat. 58-55-35.

The North Carolina Healthcare Association did not provide any additional commentary with its opposition to this Bill.

SB 646 – Amend Certificate of Need Laws

In contrast to SB 539, this Bill would only amend the language of North Carolina’s certificate of need legislation. The stated purposes of this Bill is to exempt certain healthcare services from certificate of need review, prohibit the state medical facilities plan from limiting gastrointestinal endoscopy rooms, and increasing the amount of bond required to contest or appeal approved certificate of need applications, and enhancing certain licensing requirements for development, acquisition, or replacement of ambulatory surgical facilities.

Accordingly, this Bill would amend a number of statutes starting with several defined terms outline in N.C. Gen. Stat. 131E-176 to include conforming changes and changes to increase specificity/clarity. The Bill would also amend N.C. Gen. Stat 131E-177 to prohibit the State Medical Facilities Plan from including policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

This Bill would also make a number of conforming changes to N.C. Gen. Stat. 131E-178, -183, -184, and -186. These changes would involve the elimination of certain requirements related to certificates of need and for the review of ambulatory surgical facilities, psychiatric facilities, and nursing care or intermediate care facilities

There are additional amendments to N.C. Gen. Stat. 131E-184 in this Bill regarding additional exemptions from certificate of need review. Specifically, this Bill adds subsection (i) to exempt the development, acquisition, construction, expansion, or replacement of a health service facility or health service that obtained certificate of need approval prior to October 1, 2019, from certificate of need review for ambulatory surgical facilities, diagnostic center, kidney disease treatment centers, chemical dependency treatment facilities, intermediate care facilities for individuals with intellectual disabilities, psychiatric hospital, or any other licensable facility as defined in G.S. 122C-3(14)b.

Additionally, this Bill would add subsection (j) to require DHHS to exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of 20 Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging.

However, a continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community. The terms "continuing care" and "lodging" are as defined in 29 G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification

requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection.

This Bill would also amend N.C. Gen. Stat. 131E-188 to increase the bond requirement to file a petition for a contested case on the approval of an applicant for a certificate of need to \$300,000 for each application that was reviewed with the application for a certificate of need that is the subject of the petition. Similarly, there is an increase to the secured bond required for appeals of a final decision granting a certificate of need of up to \$500,000 in the court's discretion.

Lastly, this Bill would amend GS 131E-147 to prohibit DHHS from issuing or renewing a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes: (1) a commitment that (i) the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least 4% of the total revenue collected for all surgical cases performed in the facility or proposed facility or (ii) to allocate the nearest hospital located in a Tier 1 or Tier 2 county an amount equivalent to 4% of the total revenue collected for all surgical cases performed in the facility or proposed facility; (2) for each year of operative a commitment to report to DHHS the total number of cases by separate payer categories; (3) a commitment to report utilization and payment data as required by G.S. 131E-214.2; and (4) for a license to operate in any county with a population of less than 150,000 as of the effective date of this act: (a) written documentation of support from each hospital located within that county, and (b) a written transfer agreement between the ambulatory surgical facility and each hospital located within that county.