This Bill Analysis reflects the contents of the bill as it was presented in committee.

HOUSE BILL 1037: COVID-19 Health Care Working Group Policy Rec.

2019-2020 General Assembly

Committee:	House Rules, Calendar, and Operations of the House	**Date:**	April 29, 2020
Introduced by:	Reps. P. Jones, White, Cunningham, Dobson	**Prepared by:**	Health Committee Staff
Analysis of:	PCS to Second Edition H1037-CSSH-30		

OVERVIEW: House Bill 1037 would enact several provisions designed to improve North Carolina's response to the COVID-19 emergency and any future pandemics. It would (1) create a state stockpile of personal protective equipment, (2) provide support to health care providers to respond to COVID-19, (3) increase the flexibility of the Department of Health and Human Services to respond to COVID-19, and (4) increase access to health care through telehealth. The bill also contains a severability clause.

The PCS amends the affirmation language in Section 2.1(a), and corrects the following two oversights in the House Health Committee: amends Section 4.4 in the current bill to remove language pertaining to mail-order prescriptions and removes Section 4.8 in the current bill that pertains to administering COVID-19 Tests by pharmacists, then renumbers the sections that follow.

CURRENT LAW: When it is necessary, the current law is *italicized* in the analysis for each individual section.

BILL ANALYSIS:

PART I. DEFINITIONS

Section 1.1 would establish definitions for "CDC," "COVID-19," "COVID-19 diagnostic test," "COVID-19 emergency," and "COVID-19 antibody test."

Section 1.1 would become effective when it becomes law.

PART II. AFFIRMATIONS OF ACTIONS TAKEN IN RESPONSE TO COVID-19

Section 2.1 expresses the General Assembly's support for the actions taken by the North Carolina Medical Board, the North Carolina Board of Nursing, other health care provider licensing boards, and the State's teaching institutions for health care providers in response to the COVID-19 emergency. The General Assembly also affirms its support for:

- Encouraging front-line health care workers, law enforcement officers, and child care workers to have priority access to a COVID-19 vaccine when it is introduced.
- Pursuing all available federal waivers for child welfare.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

- Providing flexibility to the State's teaching institutions for health care providers to ensure their students complete the necessary clinical hours.

Section 2.1 would become effective when it becomes law.

PART III. INCREASED ACCESS TO MEDICAL SUPPLIES NECESSARY TO RESPOND TO COVID-19 AND FUTURE PUBLIC HEALTH EMERGENCIES

Section 3.1: State Plan for a Strategic State Stockpile of Personal Protective Equipment and Testing Supplies for Public Health Emergencies

Section 3.1(a) would establish definitions for "acute care providers," "first responders," "health care providers," "long-term care providers," and "non-health care entities."

Section 3.1(b) would direct the Division of Public Health (DPH) and the Division of Health Service Regulation (DHSR), in conjunction with the North Carolina Division of Emergency Management to develop a plan for creating and maintaining a strategic state stockpile of personal protective equipment (PPE) and testing supplies. This plan must be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

Section 3.1(c) would require the plan to include:

- Recommendations about which agency should lead the stockpile effort.
- Improvements to the state procurement process for PPE.
- Recommendations on who should have access to the stockpile.
- Ways to increase production of PPE within the state.
- Recommendations about procuring testing supplies.
- Potential locations for the stockpile.
- Recommendations about the source, type, quality, and quantity of PPE and testing supplies the State should maintain.
- An inventory mechanism.
- A five-year budget.
- Any other items deemed necessary.

Section 3.1 would become effective when it becomes law.

Section 3.2: Priority Consideration of North Carolina Based Companies When Addressing Public Health Emergencies

Section 3.2 would require DHHS and the Division of Emergency Management to first consider North Carolina based companies when creating mobile response units.

Section 3.2 would become effective when it becomes law.

PART IV. SUPPORT FOR HEALTH CARE PROVIDERS TO RESPOND TO COVID-19

Section 4.1: Dental Board Flexibility During Disasters and Emergencies

Under current law, the Board of Dental Examiners does not have the authority to waive any statutory requirements in an emergency. The Medical Board and the Board of Nursing do have the authority to waive statutory requirements in an emergency.

Section 4.1 would amend the Dental Practice Act to give the Board of Dental Examiners the authority to waive requirements of the Act and the Dental Hygiene Act during a declared state of emergency in order to permit the provision of dental care during the emergency.

Section 4.1 would become effective when it becomes law.

Section 4.2: Authorization for Dentists to Administer COVID-19 Tests

Section 4.2 would amend the definition of the practice of dentistry in G.S. 90-29(b) to include the administration of COVID-19 diagnostic and antibody tests.

Section 4.2 would become effective when it becomes law.

Section 4.3: Authorization Process for Immunizing Pharmacists to Administer COVID-19 Immunizations/Vaccines

Section 4.3(a) would allow any individual to petition the State Health Director to authorize immunizing pharmacists to administer a COVID-19 vaccine by means of a statewide order if one is approved by the CDC at a time when the General Assembly is not in session. The Director would have to consult with stakeholders before issuing a decision on the petition.

Section 4.3(b) would allow the Director to issue a statewide standing order allowing immunizing pharmacists to administer a COVID-19 vaccine and make any statewide standing order issued by the Director expire upon the adjournment of the next regular session of the General Assembly.

Section 4.3(c) would require the Director to submit a minimum standard screening questionnaire and safety procedures for written protocols for the vaccine to the Joint Legislative Oversight Committee on Health and Human Services, the North Carolina Medical Board, the North Carolina Board of Nursing, and the North Carolina Board of Pharmacy within 10 days of approving the petition. If the Director does not do so, those protocols must be developed by the Immunization Branch of the Division of Public Health.

Section 4.3(d) would make the Director and any pharmacists administering COVID-19 vaccinations pursuant to the Director's order immune from civil and criminal liability.

Section 4.3 would become effective when it becomes law.

Section 4.4: Prescription Identification Requirements.

Section 4.4 would allow pharmacists to use the visual inspection of any government-issued photo I.D. to identify patients picking up prescriptions. Pharmacists would also be permitted to identify known customers by examining existing records. A pharmacist is not relieved of the duty to review information in the controlled substances reporting system.

Section 4.4 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier.

Section 4.5: Temporary Flexibility for Quality Improvement Plans

Under current law, physician assistants and nurse practitioners must establish a practice arrangement with a licensed physician. One element of this arrangement is that the physician assistant or nurse practitioner must meet periodically with the physician as part of a quality improvement process. These

arrangements must be renewed annually. There is an annual license renewal fee that physician assistants and nurse practitioners must pay.

Section 4.5(a) would establish definitions for "quality improvement plan rules," "application fee rules," and "annual renewal rules."

Section 4.5(b), (c), and (d) would prohibit the Medical Board and the Board of Nursing from enforcing any administrative rule that required any of the following:

- Quality improvement meetings between a physician and a physician assistant or nurse practitioner who had been practicing prior to February 1, 2020, and was continuing to practice when the section is enacted.
- Monthly quality improvement meetings between a physician and a physician assistant or nurse practitioner during the first six months of the practice arrangement.
- Any quality improvement meetings or payment of a license fee by a physician assistant or nurse practitioner who is providing volunteer services in response to the COVID-19 pandemic.
- The annual renewal or review of any practice arrangement between a physician and a physician assistant or nurse practitioner.

Section 4.5 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier.

Section 4.6: Pandemic Health Care Workforce Study

Section 4.6 (a), (b), (c), (d), and (e) would charge the North Carolina Area Health Education Center (NC AHEC) with studying the issues that impact health care delivery and the health care workforce during a pandemic, including issues that need to be addressed in the aftermath of this pandemic and plans that should be implemented in the event of a future health crisis. Input must be solicited from all relevant stakeholders. Issues to be examined include:

- Adequacy of the health care workforce supply to respond to a pandemic by setting.
- Adequacy of the health care workforce supply to address the COVID-19 surge.
- Adequacy of the health care workforce training, by setting.
- Impact of the COVID-19 pandemic on communities with pre-existing workforce shortages.
- Impact of Personal Protective Equipment (PPE) availability on the health care workforce, by setting.
- Sufficiency of support mechanisms for the health care workforce.
- Impact of postponing or eliminating non-essential services and procedures on the health care workforce.
- Impact of postponing or eliminating non-essential services and procedures on hospitals, particularly rural hospitals.
- Interruptions on the delivery of routine health care during the COVID-19 pandemic.
- Impact of the COVID-19 pandemic on the delivery of behavioral health services.

- Ability of telehealth options to deliver routine and emergent health and behavioral health services to patients.
- Impact of telehealth on hospitals during the COVID-19 pandemic.
- Support necessary to resume health care delivery to pre-pandemic levels.
- Ability of the health care workforce and health care delivery structure to respond to the needs of minority populations, individuals with health disparities, and individuals and communities with increased health risks during a pandemic.
- Impact of the COVID-19 pandemic, including concerns surrounding PPE availability, on current health sciences students and implications for future students contemplating a career in health sciences.

The NC AHEC would be required to report findings and recommendations to the House Select Committee on COVID-19, Health Care Working Group, on or before November 15, 2020. The NC AHEC would also be authorized to report subsequent study findings and recommendations, as appropriate, to the Joint House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services.

Section 4.6 would become effective when it becomes law.

Section 4.7: Health Care Provider Liability Protection for Emergency or Disaster Treatment

Section 4.7 would grant health care facilities and providers immunity from civil or criminal liability for acts and omissions in the course of arranging health care services if all of the following apply:

- The services are provided pursuant to a COVID-19 emergency.
- The health care services are impacted by (1) a provider or facility's decisions in response to the COVID-19 epidemic, or (2) by the decisions or activities, in response to or as a result of the COVID 19 epidemic, of a health care facility or entity where a health care provider provides health care services.
- The health care facility or provider is arranging the services in good faith.

Immunity would not apply if the damages were caused by willful or intentional misconduct, gross negligence, reckless misconduct, or intentional infliction of harm on the part of the health care facility or provider. Volunteer organizations would be immune from liability for damages that occur at their facility unless the volunteer organization unless there was willful or intentional misconduct, gross negligence, reckless misconduct, or intentional infliction of harm on the part of the volunteer organization.

Section 4.7 would become effective when it becomes law and would apply retroactively to all acts omissions, or decisions on or after March 10, 2020 that serve as a basis to a claim.

Section 4.8: Dispense and Use of Controlled Substances Temporarily at Additional Places of Business

Section 4.8 would allow licensed hospitals, nursing homes, and clinics to dispense controlled substances at additional business locations, provided that they followed a registration process developed by the

Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the North Carolina Department of Health and Human Services.

Section 4.8 would become effective when it becomes law and expire 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

Section 4.9: Pre-Procedure COVID-19 Test Result Reporting

Section 4.9 would require healthcare providers to report the results of COVID-19 testing performed prior to non-emergency surgery to the Commission for Public Health.

Section 4.9 would become effective when it becomes law.

PART V. INCREASED FLEXIBILITY FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO RESPOND TO COVID-19

Section 5.1: Extension of Time for Establishing Connectivity to the State's Health Information Exchange Network Known as HealthConnex

Under current law, most healthcare providers in the state are required to connect to the health information exchange and submit demographic and clinical data by June 1, 2020. Most providers who are not connected by that date will be ineligible to receive state funds.

Section 5.1(a) and (b) would extend the deadline from June 1, 2020, to October 1, 2021, for most providers and entities to begin submitting demographic and clinical data to the Health Information Exchange Network and make other conforming changes.

Section 5.1 would become effective when it becomes law.

Section 5.2: Temporary Waiver of Three-Year Fingerprinting Requirement/Child Care Providers

Section 5.2(a) would temporarily waive the requirement that all child care providers complete a fingerprint-based criminal history check every three years.

Section 5.2(b) would clarify that name-based background checks must continue to be performed in accordance with Federal law. Fingerprint checks would be resumed 60 days after Executive Order 116 is rescinded.

Section 5.2(c) would require DHHS to temporarily waive fingerprint background checks for adoptions, foster care, or child care institutions. Name-based background checks must continue to be performed in accordance with Federal law. Fingerprint checks would be resumed 60 days after Executive Order 116 is rescinded.

Section 5.2 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier.

Section 5.3: Provide Medicaid Coverage for COVID-19 Testing to Uninsured Individuals in North Carolina During the Nationwide Public Health Emergency

Section 5.3 would authorize DHHS to provide Medicaid coverage for COVID-19 testing for the uninsured during the nationwide coronavirus public health emergency as allowed under the Families First Coronavirus Response Act. The coverage may be retroactive to the extent allowed.

Section 5.3 would become effective when it becomes law.

Section 5.4: Temporary Medicaid Coverage for the Prevention, Testing, and Treatment of COVID-19

Section 5.4 (a) and (b) would authorize DHHS to provide temporary, targeted Medicaid coverage to individuals with incomes up to 200% of the federal poverty level, as described in the 1115 waiver request that DHHS submitted for federal approval. Coverage for this group cannot exceed coverage of services for the prevention, testing, and treatment of COVID-19, and must be for a limited time period related to the nationwide coronavirus public health emergency. The coverage may be retroactive to the extent allowed.

Section 5.4 would become effective when it becomes law.

Section 5.5: Support Receipt of Enhanced Federal Medicaid Funding

Section 5.5 would require DHHS to follow all federal laws and regulations necessary to receive the enhanced federal Medicaid funding available under the federal Families First Coronavirus Relief Act (FFCRA), notwithstanding any State law to the contrary. This section also acknowledges that the FFCRA supersedes and preempts State law requirements to the contrary.

Section 5.5 would become effective when it becomes law.

Section 5.6: Disabled Adult Child Passalong Eligibility/Medicaid

Section 5.6 would eliminate the requirement that an individual must have received a Supplemental Security Income (SSI) payment to qualify for the Disabled Adult Child passalong in the Medicaid program, no later than June 1, 2020.

Section 5.6 would become effective when it becomes law.

Section 5.7: Modification of Facility Inspections and Training to Address Infection Control Measures for COVID-19

Section 5.7(a) would instruct the Department of Health and Human Services, Division of Health Service Regulation (DHSR), and local departments of social services to suspend all annual inspections, regular monitoring requirements, and adopted rules for licensed facilities for persons with disabilities or substance use disorders, adult care homes, hospitals, health care facilities licensed under Article 6 of Chapter 131E, and hospices. Annual inspections, regular monitoring requirements, or adopted rules deemed necessary by DHSR to avoid serious injury or death, or as directed by CMS, would not be suspended.

Section 5.7(b) would require DHSR to review the compliance history of facilities for persons with disabilities or substance use disorders and adult care homes found to be in violation, assessed penalties, or placed on probation within the six-month period preceding the beginning of the COVID-19 emergency for noncompliance with rules or CDC guidelines regarding infection control or the proper use of personal

protective equipment. Employees of these facilities must undergo immediate training, permissible by video conference, about infection control and the proper use of personal protective equipment

Section 5.7 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier.

Section 5.8: Allow Temporary Waiver of 72-Hour Pre-Service Training Requirement/Child Welfare Staff

Section 5.8 would allow the Department of Health and Human Services, Division of Social Services, to waive the 72-hour requirement of preservice training before child welfare services staff assumes direct client contact responsibilities. The Division is authorized to use web-based training in order to meet preservice training requirements.

Section 5.8 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier.

PART VI. INCREASED ACCESS TO HEALTH CARE THROUGH TELEHEALTH TO RESPOND TO COVID-19

Section 6.1: Expanded Use of Telehealth to Conduct First and Second Involuntary Commitment Examinations During the COVID-19 Emergency

Under current law, individuals taken into custody for involuntary commitment must have a first examination conducted by a commitment examiner without unnecessary delay. There is no provision for this examination to be conducted via telehealth, except in cases where geographic distance is an issue. A second examination must be conducted within 24 hours of the first examination.

Section 6.1(a) would establish definitions for "Commitment examiner," "Telehealth," and "Qualified professional."

Section 6.1(b) and (c) would allow the first and second examinations, respectively, to be conducted via telehealth, provided that the commitment examiner is reasonably certain that a different result would not have been reached in a face-to-face examination.

Section 6.1 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier.

Section 6.2: Health Benefit Plan Coverage of Telehealth

Section 6.2(a) would add a new section to Article 50 of Chapter 58 that would define "health benefit plan," "telehealth," and "virtual healthcare" and require insurers and the State Health Plan to:

- Provide coverage for telephonic healthcare and electronic patient visits, both of which would be considered virtual healthcare.
- Provide coverage for provider-to-provider consultations conducted via virtual healthcare if those consultations would have been covered if they had been face-to-face.

- Cover telehealth and virtual healthcare services without prior authorization or any limits on the originating or distant sites.
- Cover physical therapy, occupational therapy, and speech therapy when delivered via telehealth.
- Not charge a greater deductible, copay, or coinsurance for services delivered via telehealth than is required for in-person services.
- Reimburse providers the same rate for telehealth services as they do for in-person services.

Section 6.2 would become effective when it becomes law and expire 60 days after Executive Order 116 is rescinded or December 31, 2020, whichever is earlier. The coverage required by section 6.2 would only be effective from (i) March 10, 2020, through the date Executive Order 116 expires or is rescinded, and (ii) the day any subsequent state of emergency is declared in response to the COVID-19 pandemic during the 2020 calendar year through 30 days after that subsequent state of emergency is rescinded.

Section 6.3: Increased Access to Telehealth Under the Medicare Program

The General Assembly urges the Centers for Medicaid and Medicare to provide coverage for health care provided through audio-only communication.

EFFECTIVE DATE: Except as otherwise provided, this act would become effective when it becomes law.

BACKGROUND: The House Select Committee on COVID-19, Health Care Working Group, consists of six Cochairs and 16 total Members. The Working Group met six times between March 26, 2020, and April 23, 2020, and heard from over 28 presenters on a range of issues impacting the delivery of health and behavioral health care. Additionally, the Health Care Working Group Members and Cochairs received information directly from a variety of entities and from the public through online comments.