HOUSE BILL 149:
Expanding Access to Healthcare.

2021-2022 General Assembly

Committee:	Senate Rules and Operations of the Senate	**Date:**	May 27, 2022
Introduced by:	Reps. Lambeth, White, Potts, K. Baker	**Prepared by:**	Jason Moran-Bates
Analysis of:	Third Edition		Staff Attorney

OVERVIEW: Part I would (i) provide Medicaid coverage through NC Health Works to adults aged 18-64 with incomes up to 133% of the federal poverty level who comply with certain work requirements; (ii) increase hospital assessments to provide funding for the NC Health Works coverage; and (iii) require the development and submission of a request to increase Medicaid reimbursements to hospitals, referred to as the Healthcare Access and Stabilization Program (HASP). Part II would require the development of the work requirements for certain individuals to be eligible for NC Health Works coverage and the submission of a request for federal approval of the requirements. Part III would make changes to Certificate of Need cost thresholds, review criteria, and administrative review process. Part IV would regulate advance practice registered nurses under the Board of Nursing. Part V would establish notice requirements for out-of-network healthcare providers who practice at in-network facilities and create requirements for telehealth.

CURRENT LAW: Current law is underlined in the Bill Analysis section for each Part of the bill when necessary.

BILL ANALYSIS:

Part I would do all of the following:

- Provide Medicaid coverage through NC Health Works to adults aged 18-64 with incomes up to 133% of the federal poverty level who comply with certain work requirements[1] established under Part II of the bill. This coverage would begin six months after the date the bill becomes law or on the effective date of the work requirements, whichever is later. (**Section 1.1**)
- Trigger the discontinuation of the NC Health Works coverage as follows: (i) if the federal share of the cost of providing the coverage becomes less than 90%, then coverage would end no earlier than the date the lower federal share is effective (**Section 1.2, G.S. 108A-54.3B**); and (ii) coverage would end as expeditiously as possible if, for any fiscal year, the nonfederal share of the cost of the NC Health Works coverage cannot be fully funded through the following sources (**Section 1.2, G.S. 108A-54.3C**):
  - Increases in revenue from the gross premiums tax due to NC Health Works coverage.

[1] For a discussion of the authority for Medicaid work requirements, see the Kaiser Family Foundation Issue Brief entitled "An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?" (May 3, 2022), available at: https://www.kff.org/medicaid/issue-brief/an-overview-of-medicaid-work-requirements-what-happened-under-the-trump-and-biden-administrations/?utm_campaign=KFF-2022-Medicaid&utm_medium=email&_hsmi=211917877&_hsenc=p2ANqtz-_HeXHcP0dqaCrOBpAGUo5WVMbW8C9g69LparGbZdAAUEd526qweSNPNxPUl2ScwJmNfBZx0FWGlHx1uzd9Y023DLN49Q&utm_content=211917877&utm_source=hs_email

  - Increases in intergovernmental transfers due to NC Health Works coverage.
  - The hospital health advancement assessment enacted in Section 1.6 of the bill.
  - Savings to the State attributable to NC Health Works coverage that correspond to State General Fund budget reductions to other State programs.

- Establish an ARPA Temporary Savings Fund to hold any savings realized by the Division of Health Benefits from the enhanced federal medical assistance percentage (FMAP) available under the American Rescue Plan Act (ARPA) for states that expand Medicaid. (**Section 1.3**)
- Increase hospital assessments to provide funding for the nonfederal share of the cost of NC Health Works coverage, as follows:
  - Establish hospital assessments to generate funding for the nonfederal share of the service costs and the administrative costs of NC Health Works, including county administrative costs. Temporary hospital assessments would generate funding for the nonfederal share of start-up costs and costs during the initial period of NC Health Works coverage (**Section 1.5**), and the hospital health advancement assessment (**G.S. 108A-147.1**) would generate continued funding beginning July 1, 2023. (**Section 1.6**)
  - Require hospital assessment funds representing the county share of administrative costs of NC Health Works coverage be paid to the counties.
  - Include a state retention component of $37.5 million per quarter ($150M annually). (**G.S. 108A-147.9**)
  - Make conforming changes to the existing modernized hospital assessments related to the addition of the NC Health Works coverage. (**Section 1.7**)
- Direct the Department of Health and Human Services (DHHS) to request approval from the Centers for Medicare and Medicaid Services (CMS) for increased Medicaid reimbursements to hospitals at the highest amount that can be funded entirely through increased hospital assessment receipts that are in addition to the receipts calculated under the hospital health advancement assessment. (**Section 1.10**) This initiative is referred to as the Healthcare Access and Stabilization Program (HASP). Any increased reimbursement to hospitals approved by CMS would not be effective until the General Assembly enacts legislation to fund the State share of that increased reimbursement.

Part II would require DHHS to develop work requirements as a contingency for certain individuals to participate in NC Health Works. The requirements would align with the work requirements for Able-Bodied Adults Without Dependents (ABAWDs) policy under the Supplemental Nutrition Assistance Program (SNAP). The work requirements would apply to all individuals who are eligible for the NC Health Works coverage added under Section 1.1 of the bill, except for the following:

- Individuals certified as unfit for employment for physical or mental health reasons.
- Individuals with a physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.
- Individuals actively participating in a substance abuse treatment and rehabilitation program.
- Parents or caretakers of a dependent child under 1 year of age.
- Parents or caretakers that provide care for a dependent child with a serious medical condition or disability, to be defined by DHHS.
- Individuals who are receiving unemployment compensation and complying with the work requirements that are part of the federal-State unemployment compensation system.

- Presumptively eligible Medicaid recipients, during the period of presumptive eligibility.
- Medicaid recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.
- Inmates of prisons.

The work requirements would become effective only upon approval by CMS and on either (i) the effective date of the approved work requirements or (ii) six months after the date this act becomes effective, whichever is later.

Part III would make the following changes to North Carolina's Certificate of Need (CON) program in Chapter 131E of the General Statutes:

- **G.S. 131E-176. Definitions** would be amended to amend the definition of "expedited review," "health service facility," health service facility bed," "new institutional health services," and "replacement equipment." A definition for "related entity" would be created. The amendments to existing definitions would have the effect of removing chemical dependency treatment facilities, ambulatory surgical facilities, psychiatric beds, chemical dependency treatment beds, MRI scanners, and replacement equipment costing less than $4 million from CON review. Currently, chemical dependency treatment facilities, ambulatory surgical facilities, psychiatric beds, chemical dependency treatment beds, MRI scanners are subject to CON review, and replacement equipment that costs less than $2 million is not subject to CON review.
- **G.S. 131E-178. Activities requiring certificate of need** would be amended to clarify that gastrointestinal endoscopy rooms do not need to obtain a CON as ambulatory surgical facilities.
- **G.S. 131E-182. Application** would be amended so that applications for similar proposals in the same service area can be reviewed together only if they are subject to the limitations set out in the State Medical Facilities Plan (SMFP). Under current law, all similar proposals in the same service area are reviewed together.
- **G.S. 131E-183. Review criteria** would be amended as follows:
    - Subdivision (a)(1) would specify that proposed projects for air ambulances, emergency rooms, adult care homes, nursing home facilities, intermediate care facilities for individuals with intellectual disabilities, linear accelerators, gamma knives, scanners, or any combination of those services must be consistent with the policies and need determinations in the SMFP and that all other proposed projects would not be subject to policies or need determinations in the SMFP. Currently all proposed projects are subject to the policies and need determinations in the SMFP.
    - Subdivisions (a)(3) and (a)(3a) would be amended to eliminate the requirement that CON applicants prove the local populations will be adequately served by the proposed project.
    - The requirement in subdivision (a)(6) that applicants demonstrate the proposed project does not result in duplication of services would be eliminated. The requirement in subdivision (a)(9) that the applicant document the circumstances that require provision of services to individuals not residing in the health service area will also be eliminated.
    - Subdivisions (a)(13) and (a)(20) would be amended to require applicants to provide evidence of past performance and meeting expectations contained in previous CON applications, regardless of where the services in those previous CON applications are located.

- A new subsection (d) would be added, requiring DHHS to adopt and publish criteria used to assess an applicant's past performance in previous CON applications.

- **G.S. 131E-184. Exemptions from review** would be amended to exempt the cost for which certain capital expenditures and replacement equipment is exempt from CON review to $4 million. The replacement, renovation, or relocation of an institutional health service or health service facility which has already been issued a CON would be exempt from further review if the service or facility is to be moved to another site in the same county. The development, acquisition, construction, expansion, or replacement of chemical dependency treatment facilities and ambulatory surgical facilities that received a CON prior to October 1, 2022, would also be exempted from CON review. The current cost cap for exemption is $2 million. Currently, replacement, renovation, or relocation is subject to CON review in most cases. The development, acquisition, construction, expansion, or replacement of chemical dependency treatment facilities and ambulatory surgical facilities is currently subject to CON review.

- **G.S. 131E-185. Review process** would be amended to remove the ability of any person to file written comments on CON applications with DHHS. DHHS would be able to hold a public hearing on an application if it determined a hearing was in the public's interest. Currently, a public hearing is required if the review is competitive, the cost of the project is $5 million or more, an affected party requests a hearing, or if DHHS determines a hearing is necessary.

- **G.S. 131E-188. Administrative and judicial review** is amended to permit only "affected applicants" to appeal the issuance, denial, or withdrawal of a CON. "Affected applicant" would be defined to mean those who submitted applications that both (i) were scheduled to be reviewed in the same review period and (ii) were part of a competitive review. If the decision is appealed, the discovery period for the contested case would last 60 days, and the contested case hearing must take place within 30 days after the discovery period. The hearing may last no more than 5 days, and expert witnesses must be qualified in the same manner as in a civil court trial. The definition for "affected person" under subsection (c) is repealed. Currently, any "affected person," as defined in subsection (c), may challenge an initial CON decision. The contested case discovery period lasts 90 days, and there is no time limit for the hearing, which must begin 45 days after the discovery period. There are no statutory qualifications for expert testimony in the contested case hearing.

This Part would also make conforming changes to several other sections in the General Statutes.

The potion of this part requiring DHHS to adopt and publish criteria to assess performance under prior CON applications would become effective when it becomes law. The criteria must be adopted and published by October 1, 2022. The remainder of this Part would become effective October 1, 2022.

Part IV would amend Chapter 90 of the General Statutes to create regulations of advanced practice registered nurses.

- **G.S. 90-171.20. Definitions** would be amended to add definitions for "advanced assessment," "advanced practice registered nurse or APRN," "license," "population focus," "practice of nursing as an advance practice registered nurse or APRN," "practice of nursing as a certified nurse midwife of CNM," "practice of nursing as a certified registered nurse anesthetist or CRNA," "practice of nursing as a clinical nurse specialist or CNS," and "practice of nursing as a nurse practitioner or NP." Technical changes to bring the statute in line with current drafting conventions would also be made throughout.

- **G.S. 90-171.23. Duties, powers, and meetings** would be amended to allow the Board of Nursing sole authority to regulate the prescribing of drugs by APRNs. Currently, this authority is jointly held by the Board of Nursing and the Medical Board.
- **G.S. 90-171.27. Expenses payable from fees collected by the Board** would establish a $100 licensure application fee, a $100 biennial license renewal fee, and a $180 lapsed license renewal fee for APRNs.
- **G.S. 90-18. Practicing without license; penalties** would be amended to clarify that practicing as an APRN is not the practice of medicine or surgery.
- **G.S. 90-18.2. Limitations on nurse practitioners**, which requires NPs to prescribe drugs only under the joint supervision of the North Carolina Medical Board and the North Carolina Board of Nursing, would be repealed.
- **G.S. 90-29. Necessity for license; dentistry defined; exemptions** would be amended to clarify that CRNAs who administer anesthetic as part of a dental procedure are not engaged in the practice of dentistry.
- Individuals would not be allowed to practice as APRNs unless licensed as APRNs by the Board of Nursing. The Board must issue APRN licenses to individuals who were recognized as APRNs prior to December 31, 2021.
- The Board of Nursing, the Medical Board, and the Board of Dental Examiners would be required to adopt rules to implement this act.
- The Governor must submit an exemption request to the Centers for Medicare and Medicaid Services to allow hospitals, ambulatory surgical centers, critical access hospitals, and rural hospitals in this State the maximum flexibility to obtain Medicare reimbursement for anesthesia services in a manner that best serves each facility and the patients and communities the facility serves. The request must be submitted within 30 days of the act's effective date.

This Part would also make conforming changes to several other sections in the General Statutes.

The provisions requiring state agencies to adopt rules and the Governor to submit an exemption request become effective when the bill becomes law. The remainder of Part IV would become effective October 1, 2022.

Part V would establish notice requirements for out-of-network healthcare providers who practice at in-network facilities and create requirements for telehealth.

- Contracts between health benefit plans and in-network health service facilities must include provisions requiring the facility to provide notice to insureds if out-of-network providers will be rendering some of the healthcare services to the insureds. The notice must include an estimate of the costs of the out-of-network services and must be provided to the insured at least 72 hours prior to the appointment, or as soon as reasonably possible if the appointment is scheduled with less than 72 hours' notice. These provisions only apply if the service being provided is anesthesia, emergency treatment, pathology, or radiology.
- Chapter 58 (Insurance) would be amended to create parameters for insurance coverage of telehealth services.

- Administrative functions, encounters where medical decision making does not occur, triage, consultations between healthcare providers, audio-only services, and remote patient monitoring would not be considered telehealth.
- Health benefit plans would be permitted to exclude coverage for telehealth services when the billing code does not accurately reflect the service provided, when the provider does not share claims data with the NC Health Information Exchange, when the service is not provided by the patient's primary care physician, when the service is provided by an out-of-network provider, and when the patient does not give informed consent to the service.

- Chapter 90 would be amended to include parameters for healthcare providers who wish to provide telehealth services.
  - Informed consent for telehealth services would require the provider to (i) identify the patient and the patient's medical history, (ii) disclose the provider's identity and credentials, (iii) disclose the delivery models and treatment methods to be used, (iv) disclose the risks and limitations of telehealth, (v) inform the patient about the purpose of telehealth, (vi) inform the patient that he or she can request an in-person consultation, (vii) provide any disclosures and obtain any consent that must be disclosed or obtained for a face-to-face encounter for the same procedure or service.
  - Before providing telehealth services, providers must (i) advise patients of the location, phone number, and regulator of the billing entity, if that information is different from that of the provider, (ii) disclose whether the provider is consider in-network or out-of-network, (iii) identify the service being provided and estimated cost of care, (iv) document informed consent, (v) store all electronic information in accordance with all relevant privacy laws, (vi) create and save a recording of the telehealth encounter, and (vii) refrain from charging a fee for sharing medical records for telehealth services or engaging in balance billing.

The portion of Part V establishing notice requirements for out-of-network providers would become effective January 1, 2023, and apply to insurance contracts entered into, amended, or renewed on or after that date. The portion of Part V requiring coverage for telehealth would be effective October 1, 2023, and apply to insurance contracts entered into, amended, or renewed on or after that date.

EFFECTIVE DATE: Except as otherwise provided, the bill would be effective when it becomes law.