North Carolina Medical Society

Leadership in Medicine

2012 LEGISLATIVE SUMMARY

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LEGISLATIVE HIGHLIGHTS IMPACTING THE PROFESSION OF MEDICINE

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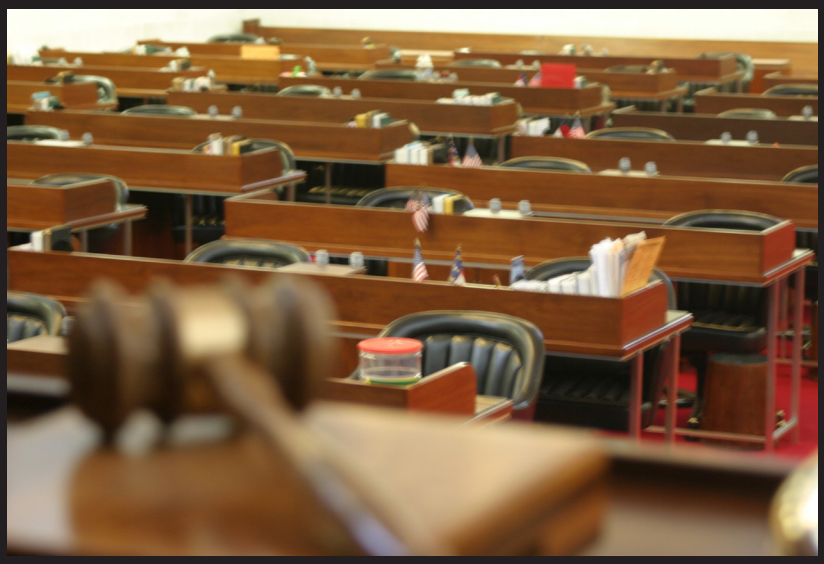
North Carolina Medical Society

Leadership in Medicine

Your future will be determined by the elected officials who fill these seats...



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2012 LEGISLATIVE SUMMARY

Overview of the Session

Message from the NCMS Legislative Cabinet Chairman

Every even numbered year, lawmakers gather in Raleigh for a short legislative session. The purpose of this "Short Session" is to evaluate the progression of the state budget and make adjustments where necessary. The 2012 short session of the North Carolina General Assembly was a seven week whirlwind of events, mostly revolving around the state's Medicaid budget.

In addition to daily work to preserve the physician fee schedule under Medicaid, the NCMS legislative team also worked to pass legislation to fix not one but two cash flow shortfalls in the program, reverse devastating cuts to therapy services, and set aside a $100 million Medicaid reserve. These efforts ensured that those of us who treat Medicaid patients continued to receive payment for those services through the end of this fiscal year and also prepares us for the future.

John L. Reynolds, MD, (left) Chair of the Legislative Cabinet, speaks with Chip Baggett, NCMS Director of Legislative Relations.

Additionally, your NCMS advocacy team put an exclamation point on the successes of 2011 by defending against any erosion to the medical liability reforms passed that year. This is a battle that we will undoubtedly continue to face each legislative session and in the courts.

As in years past, this session also brought with it continued efforts to license new healthcare providers in our state including naturopaths and lay midwives. While these efforts were unsuccessful in 2012, the NCMS is confident that these proposals will resurface in 2013.

All in all, the work of your Medical Society resulted in an extremely successful 2011-2012 Legislative Session. These important wins could not have been accomplished without your efforts to advocate for our profession. This year's session may have come to a close, but now is the time for our real work to begin – building relationships with legislators and educating ourselves on the issues that lie ahead.

Please join me in shaping the future of medicine in North Carolina.

John L. Reynolds, MD

MODIFY 2011 APPROPRIATIONS ACT

NCMS Position: Support

House Bill 950

Sponsor: Brubaker (R78)
Status: 07/02/2012 – Chaptered Session Laws

Summary: There were no rate cuts for physician services in Medicaid for 2012. This is welcome news across all of North Carolina. While many physicians are still reeling from the massive cuts to Medicaid reimbursement made in 2009 and 2010, it is refreshing to see the NC General Assembly fully fund Medicaid with the state dollars necessary for federal matching funds. That's two years without a physician rate cut even in the midst of a down economy and budget consolidation.

To fully comprehend the magnitude of the commitment that was made to the physicians and patients of NC this year, you have to understand some history. As the economy began the downward spiral in 2008, the federal government recognized that states were going to need additional help to maintain their Medicaid rolls. To help relieve pressure, President Obama and the Congress agreed to temporarily increase the federal match rate from 66% to nearly 75%. This was a huge influx of money for the states. In North Carolina alone, this new match rate would bring in more than $800 million in 2009 and nearly $400 million in 2010. This is match money to be used after services have been provided and state dollars have been spent.

However, the 2009 – 2010 leadership of the NCGA did not view this money as temporary Medicaid assistance. They viewed this federal draw down as a way to supplement the state's revenue losses generally. Despite this new money, the 2009 biennium budget as well as the 2010 continuation budget still included massive cuts for Medicaid services beyond those considered to be substantially focused on primary care. That means that all but 81 billing codes were cut by roughly 9%. In the same years, lawmakers decided to add on a new fee of $100 for every Medicaid provider in order to enroll to see Medicaid patients. The Health and Human Services budget took a nearly 35% cut overall in these years while education and other departments' budget impact was limited.

These reductions in services, reimbursement and coverage forced physicians to take a long hard look at where lawmaker's priorities were really focused. NCMS staff and NC physicians set out to educate legislators and legislative candidates in 2010 about the threats to public health and safety that were occurring as a result of this unfair treatment. Even during this grassroots effort, a third reimbursement cut continued to loom.

In 2011, a new leadership team took control of the NC General Assembly. One of the first bills passed that year protected physicians and other Medicaid providers from the additional cut still left over from the 2010 budget adjustments. With the assistance of legislators like Sen. Pete Brunstetter (R-Forsyth) and Rep. Nelson Dollar (R-Wake), we were able to begin focusing Medicaid dollars on Medicaid services instead of using those dollars to supplement other areas of the budget. Even with NC facing a $2 billion budget adjustment, legislators stood fast to funding Medicaid appropriately, or at least to the extent that they were aware would be necessary.

As early as January of 2012, budget writers began to get briefings about a number of "off-the-book" costs that were looming over the Department of Health and Human Services (DHHS) budget. Lawsuits, federal fines and borrowing from one year to pay for the next were all beginning to take a serious toll on the cash flow availability of DHHS. This was especially evident because the NC General Assembly had restricted budget fund re-appropriations in the 2011-2013 budget. This all led to the need for another bill at the beginning of the 2012 Short Session to save Medicaid and continue to pay providers for the services they had rendered to patients on behalf of the state.

Legislators signed off on over $200 million dollars to fund these services, lawsuits and fines in May of 2012. All the while, budget writers were trying to find additional funds for federally funded teacher positions that would be lost this year. Funds from the hospital assessment that had contributed to protecting physicians from a cut in 2011 were slow to come in, but the paperwork obstacles seemed to be overcome by DHHS staff as we entered into the short session. But the task of right sizing the budget was still not complete because the economic recovery was still slower than expected.

While additional cuts were considered and the budget process was almost derailed by continued cash flow problems, on June 21st the NC House and Senate passed concurrence votes giving final approval to a $20.12 billion budget for 2013. This budget includes a reserve for Medicaid in the event that spending forecasts are not on target as well as the following highlights:

- A bar on any further provider rate cuts for this fiscal year.
- Increased savings target for Community Care of North Carolina (total new savings required is now more than $160 million).
- A repeal of the cap on physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services outlined in last year's budget.
- Directions to transition next spring to a decision support-based system for managing high cost imaging services.
- $6 million reduction in personal care service funding.
- $5 million in reductions to non-state entities that traditionally receive funding.
- $25 million in temporary transitional funding to implement the new state Community Living Plan.
- $9 million in additional funds for community hospital beds for mentally ill patients.
- $7 million in additional funds for Cherry and Broughton Hospital.
- $1.6 million for the CheckMeds program.
- Funding for the high risk maternity clinic at Eastern Carolina University (ECU).
- $2.7 million for tobacco cessation efforts.

Despite Governor Perdue's veto of this budget, it became law on July 2, 2012 when six Democrats joined the 68 House Republicans to override the veto. They included Rep. Jim Crawford (D-Granville), Rep. William Brisson (D-Bladen), Rep. Dewey Hill (D-Columbus), Rep. Marcus Brandon (D-Guilford), Rep. Darren Jackson (D-Wake), Rep. Marian McLawhorn (D-Pitt). Rep. Susi Hamilton (D-New Hanover) was not present for the vote. These Democrats showed incredible fortitude by standing with you and your patients to ensure that a real and accurate Medicaid budget emerged from this process. If not for their support, Medicaid shortfalls and most likely further Medicaid cuts would have taken effect over the next year.

Brian Kuszyk, MD and Rep. Marian McLawhorn (D-Pitt)

EXPAND PHARMACISTS' IMMUNIZING AUTHORITY

NCMS Position: Oppose

Senate Bill 246

Sponsor: Hartsell (R36)
Status: 06/09/2011 – House Committee on Health and Human Services

Summary: The role of pharmacists in administering additionalimmunizations has been a topic of discussion at the General Assembly throughout the past two years. In 2011, SB 246 was filed with the goal of legislating the authority of pharmacists to administer many new immunizations to both adults and children. Under current law, expansion of such authority can be approved by mutual rulemaking of the State Medical, Pharmacy and Nursing Boards.

With well-known opposition from the NCMS, the NC Academy of Family Physicians and the NC Pediatric Society SB 246 underwent a total of 5 re-writes before the end of the 2011 session. However, in the final days of that session, one piece of this legislation was rolled into another bill, allowing immunizing pharmacists to administer flu vaccines to any individual age 14 and over. The remainder of HB 246 was referred to a subcommittee of the House Health and Human Services Committee.

Leading into the 2012 short session, Representative Tom Murry (R-Wake) informally proposed several revisions to SB 246. However, each of these proposals fell short of the NCMS, NCAFP and NCPS concerns regarding the need for physician evaluation and counseling prior to the administration of some immunizations. While rigorously debated among stakeholders behind the scenes, the House Health Committee's Subcommittee appointed to consider this legislation did not meet during the 2012 short session and SB 246 did not become law.

NATUROPATHIC LICENSING ACT

NCMS Position: Oppose

Senate Bill 467

Sponsors: Hartsell (R36), Apodaca (R48)
Status: 06/14/2011 – Senate Committee on Finance

Summary: The Naturopathic Licensure Act is discussed each year at the NC General Assembly. However in 2012 the bill was heavily supported by two new sponsors, also members of the Senate's Republican leadership. This bill proposes to create a new category of physician in North Carolina, referred to as NDs or Naturopathic Doctors. These individuals attend a four-year naturopathic school in lieu of medical school and seek to diagnosis and treat major illness, perform and interpret diagnostic imaging tests, and advertise themselves as doctors. There are approximately 30 individuals in North Carolina who would qualify for ND status under the provisions of this bill. Following a number of stakeholder meetings held at the request of the bill sponsors during the short session, consensus could not be reached between the medical community and the naturopaths. It is expected that advocates for this bill will reintroduce similar legislation in 2013.

MIDWIFERY LICENSING ACT

NCMS Position: Oppose

House Bill 522

Sponsors: Wilkins (D55), Hurley (R70), Current (R109), Carney, B. (D102)
Status: 03/30/2011 – House Committee on Health and Human Services

Frank Harrison, MD speaks to House Health Committee regarding dangers of CPM licensure.

Summary: House Bill 522 seeks to establish a second midwifery licensure board for the state of North Carolina for the purpose of licensing Certified Professional Midwives (CPMs). CPMs are non-nurse, direct-entry midwives who attend homebirths. The lack of educational and training requirements in HB 522 puts North Carolina families at great risk. In response to continued advocacy by the proponents of this bill, the House Health Committee did discuss House Bill 522 during the short session. However, no vote was taken. The NCMS and the North Carolina OBGYN Society opposed this legislation and physicians spoke out against its passage at the House Health Committee meeting. Although this bill did not move forward during the 2011-2012 Legislative Session, the NCMS legislative team expects it will reappear in 2013. Protecting NC families and opposing CPM licensure remains a top priority of the North Carolina Medical Society.

ELECTROLYSIS PRACTICE ACT CHANGES/FEES

NCMS Position: Oppose

House Bill 1105

Sponsor: Justice (R16)
Status: Converted into another bill.

Amy Fox, MD and Craig Burkhart, MD Kick-off the NC Dermatology Association's skin cancer screening at the NC General Assembly.

Summary: Early in the 2012 short session new legislation was filed to make changes to the Electrolysis Practice Act. House Bill 1105 would have authorized a reduction in certain fees charged by the Board of Electrolysis Examiners. Additionally the bill would have waived the 30 hour certification requirement for anyone seeking to serve as a laser practitioner instructor as long as that individual was practicing prior to October 1, 2007. The NCMS and the NC Dermatology Association opposed this provision of the bill. Before being heard in committee this legislation was gutted and used as a vehicle for unrelated legislation thereby leaving the Electrolysis Practice Act unchanged.

BEHAVIOR ANALYSIS PRACTICE ACT

House Bill 1157

Sponsors: Parfitt (D44), Shepard (R15), Parmon (D72)
Status: 05/30/2012 – House Committee on Health and Human Services

Summary: In the months leading up to the 2012 short session, the House Select Committee on Military Affairs met and made recommendations to the General Assembly regarding military and veterans issues. One recommendation of the committee is to license board certified behavior analysts and behavior analyst assistants in our state. This bill proposed the addition of a Behavioral Analysis Practice Act to Chapter 90 of the General Statutes. Such providers would be regulated under the NC Psychology Board and would be required to arrange face-to-face supervision under a licensed psychologist or psychological associate. The practice of medicine, optometry and psychology would all be prohibited under the provisions of HB 1157. This bill was introduced but never discussed during the short session.

LICENSURE BY ENDORSEMENT/MILITARY SPOUSES

House Bill 799

Sponsors: Martin (D34), Killian (R105)
Status: 07/24/2012 – Chaptered Session Laws

Summary: Introduced in 2011, House Bill 799 streamlines the process for military-trained applicants and their spouses to receive a license from a North Carolina occupational licensing board. The bill specifically excludes the practice of law and was amended on the House floor to also exclude the North Carolina Medical Board from the provisions of the bill.

PATIENT ACCESS TO PATHOLOGICAL MATERIALS

NCMS Position: Oppose

House Bill 795

Sponsors: Steen (R76), Murry (R41), McComas (R19)
Status: 05/19/2011 – Senate Committee on Health Care

Summary: In 2011 Representative Fred Steen (R-Rowan) introduced HB 795 with the goal of reducing the amount of paperwork required of patients when attempting to access their own pathological materials. After several amendments were made on the House floor the bill would require the release of all of the following materials in the provider's possession: a patient's cytological materials, bodily fluids, tissues, organs, medical waste, paraffin blocks, pathology slides, reports and medical records. The NCMS, along with the NC Society of Pathologists and the NC Hospital Association raised a number of concerns regarding both the need for this legislation as well as the public health risks posed by this bill. Several stakeholder meetings were held on this issue during the 2012 short session, many up until the final days of session, however the bill was not acted on in the Senate prior to adjournment. It is expected that this legislation will become a topic of discussion for the Legislative Research Commission between now and the start of the 2013-2014 session.

STATE HEALTH PLAN/ADD SCHOOLS; WHISTLEBLOWERS

House Bill 244

Sponsor: Murry (R41)
Status: 07/17/2012 – Chaptered Session Laws

Summary: This legislation was introduced in 2011 as a bill related only to allowing certain charter schools to enroll its employees into the State Employees Health Plan. At the close of the 2011 legislative session HB 244 had received passage by the House of Representatives and was sitting unheard in the Senate Committee on Insurance. During the 2012 short session this bill was heard by that Committee with some additions proposed by Senator Ralph Hise (R- Mitchell). That additional language approved by the Committee on Insurance and eventually both chambers encourages individuals to report evidence of illegal activity, fraud or gross mismanagement of resources related to the State Employees Health Plan. The bill protects those that make reports from retaliation by their employer.

FREEDOM TO NEGOTIATE HEALTHCARE RATES

NCMS Position: Support

Senate Bill 517

Sponsor: Apodaca (R48)
Status: 6/26/2012 – House Judiciary Subcommittee B

Summary: Senator Apodaca introduced the "Freedom to Negotiate Health Care Rates" bill, which would allow health providers and health insurers to freely negotiate reimbursement rates and prohibit contract provisions that restrict such negotiations. This is also known as Most Favored Nation legislation.

Specifically, the Bill seeks to eliminate contract provisions that: (1) prohibit, or grant an insurance carrier the option to prohibit, a provider from contracting with another insurance carrier to provide services at a rate equal to or lower than the payment required in the contract; (2) require a provider to accept a lower payment rate if said provider agrees to provide care at a cost equal to or lower than the payment specified in the contract to another insurance carrier; (3) require, or grant an insurance carrier the option to require, terminate, or renegotiate, existing health care contracts if the provider agrees to provide services to any other insurance carrier at a rate equal to or lower than that specified in the contract; (4) require, or grant an insurance carrier the option to require, a provider to disclose the provider's contractual rates with another insurance carrier; (5) require, or grant an insurance carrier's option to require, the non-negotiated adjustment by the insurer of a provider's contractual rate to equal the lowest rate the provider has agreed to charge any other insurance carrier; and (6) require, or grant an insurance carrier an option to require, a provider to charge another insurance carrier a rate that is equal to or more than the reimbursement specified in the contract.

RIGHT TO CHOOSE PHYSICAL THERAPIST

Senate Bill 656

Sponsor: Davis (R50)
Status: 06/29/2012 – Chaptered Session Laws

Summary: Senate Bill 656 stipulates that when an insurer provides coverage or reimbursement for physical therapy services, such services will be reimbursed whether they are performed by a physician or by a physical therapist – as long as such services are within that physical therapist's scope of practice under North Carolina law. The bill also allows patients to choose their physical therapist for such services, with exceptions for network provider requirements of payers. Current law provides the same rights to patients of optometrists, podiatrists, dentists, chiropractors and many other healthcare providers.

Medicaid Fraud and Abuse

CHILD PROTECT. SERV/CHILD CARE SUB./RENT EXEMPT

NCMS Position: Oppose

House Bill 423

Sponsor: Hurley (R70)
Status: 06/11/2012 – Senate Committee on Rules and Operations of the Senate

Summary: House Bill 423 received passage by the House in 2011 in the form of a bill to enact the state's First Evaluation Pilot Program. However, with the passage of SB 437 in the same year, this bill was no longer necessary and in 2012 became a vehicle for new legislation. During the short session the language of HB 423 was substituted for legislation related to funding for child protective services and child care subsidy vouchers. However, Section 3 of the new bill would have also redefined "substantial compliance" under Medicaid to mean that within a sampling of a provider's claims less than 20% are found to violate federal or state regulation or met the definition of abuse. Under current law no specific percentage threshold exists. This provision was discussed in a stakeholders meeting in which the NCMS participated, however the bill never received approval by the Senate Committee on Mental Health and Youth Services or the Senate Committee on Rules.

Holly Biola, MD meets with Senator Bob Atwater (D-Chatham).

Government Efficiency Bills

BOARDS & COMMISSIONS EFFICIENCY ACT OF 2012

Senate Bill 851

Sponsors: Brown, H. (R6), Rouzer (R12), Soucek (R45)
Status: 06/06/2012 – Senate Committee on Finance

Summary: This broad sweeping legislation proposed to streamline many state boards and commissions and to either sunset or completely eliminate many others. Among those included in the bill were the following:

- The Commission of Anatomy renamed The Commission for Public Health
- Eliminate the North Carolina Center for Nursing
- Eliminate the Legislative Commission on Methamphetamine Abuse
- Eliminate the Mine Safety and Health Advisory Council
- Sunset the North Carolina Brain Injury Advisory Council in 2015
- Sunset the Child Fatality Task Force in 2015
- Eliminate the Justus-Warren Heart Disease and Stroke Prevention Task Force
- Reduce the number of members on the North Carolina Institute of Medicine Board of Directors, the North Carolina Council for the Deaf and Hard of Hearing, the Local Health Department Accreditation Board, the Commission for Public Health, and the Minority Health Advisory Council.

This legislation was introduced and debated in the 2012 short session but was not voted on and did not become law.

Public Health

ACCOUNTABLE CO. COMMS/EXPAND LOC. BD. AUTH

NCMS Position: Oppose

House Bill 438

Sponsor: McComas (R19)
Status: 06/29/2012 – Chaptered Session Laws

Summary: House Bill 438 rewrote sections of North Carolina General Statutes Chapter 153A (Counties) and added new sections to Article 2 of Chapter 130A (Public Health).

Chapter 153A
Amendments to § 153A-77 now require boards of county commissioners to appoint an advisory

committee if a board has assumed direct control of a local health board after January 1, 2012, but has not delegated the powers and duties of the health board to a consolidated health service board. A consolidated human services board not exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board must consist of four members who are consumers of human services. However, if the county is exercising the aforementioned powers and duties, then the consolidated human services board of that county has the authority to plan comprehensive mental health services.

N.C. Gen. Stat. § 153A-76 (Board of Commissioners to Organize County Government) now prohibits the Board from: (1) abolishing or consolidating into a human services agency a hospital authority or public health authority assigned to provide public health services pursuant to Section 12 of S.L. 1997-502 and N.C. Gen. Stat. § 130A-1.1, respectively; (2) consolidating an area mental health, developmental disabilities, and substance abuse services board into a consolidated human services board or abolish the former, subject to Chapter 122C of the General Statutes; and (3) abolishing, assuming control over, or consolidating into a human services agency a public hospital.

Article 2 of Chapter 130A

A new incentive program, the Public Health Improvement Incentive Program, § 130A-34.3, provides monetary incentives for the creation and expansion of multicounty local health departments serving populations of at least 75,000 people. The Commission for Public Health will adopt specific rules to implement the program.

To strengthen local public health infrastructure, the bill established new criteria that local health departments must meet by July 1, 2014, to be eligible to receive State and federal public health funding (in addition to any other funding criteria established by State or federal law). The new criteria enumerated under § 130A-34.4 include obtaining and maintaining accreditation, and the county's duty to maintain appropriations to its health department from local property tax receipts at levels equal to amounts appropriated during State fiscal year 2010-2011.

Finally, § 130A-1.1(b) was rewritten to ensure that citizens have access to 10 essential public health services. The services include, among others, monitoring health status to identify community health problems, conducting research, and developing policies and plans that support individual and community health efforts. All local health departments are required to provide the 10 services.

Mental Health

ELIMINATE LME PROVIDER ENDORESEMENT - AB

House Bill 1055

Sponsors: Burr (R67), Dollar (R36)
Status: 06/26/2012 – Chaptered Session Laws

Summary: House Bill 1055 withdrew the authority of the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to endorse mental health, developmental disabilities, and substance abuse services providers. Accordingly, the bill also eliminated a local management entity's power to remove the Commission's endorsement.

The Law also amended the definition of a "contractor" under N.C. Gen. Stat. § 122 C-151.4(a) so that a contractor no longer includes one "whose application for endorsement has been denied by an area authority or county program."

PROVISIONAL LIENSURE CHANGES MEDICAID - AB

House Bill 1081

Sponsors: Burr (R67), Dollar (R36)
Status: 06/26/2012 – Chaptered Session Laws

Summary: The Psychology Practice Act was rewritten to allow the issuance of a provisional psychologist license or a psychological associate license if a psychologist meets all other requirements to become a licensed psychologist under N.C. Gen. Sta. § 90-270.11(a) except for two years of supervised experience. Furthermore, the amended law no longer addresses whether the Board has the authority to place a psychologist on inactive service for failure to complete two years of supervised experience.

For N.C. Gen. Stat. §§ 90B-3, 90B-7(f), 90B-16(a), 90-113.31A, 90-113.31A, 90-113.42(d), and 90-113.43, the bill also replaced "Provisional Licensed Clinical Social Worker" with "Licensed Clinical Social Worker Associate," "Provisional licensed clinical addictions specialist" with "Licensed Clinical Addictions Specialist Associate," and "provisional" and "provisionally" with "associate."

Lastly, the bill expanded the available EPSDT services for children to include mental health services provided by licensed clinical social workers associates (formerly provisional licensed clinical social workers), licensed professional counselor associates, licensed marriage and family therapist associates, and licensed clinical addiction specialists associates (formerly provisional licensed clinical addictions specialists).

Will Barnett; Jessica Scott, MD, JD; Prashant Patel, MD; and Bill Farrell, MD at NC General Assembly.

LME GOVERNANCE

Senate Bill 191

Sponsor: Mansfield (D21)
Status: 07/12/2012 – Chaptered Session Laws

Summary: Senate Bill 191 made significant changes to the governance of local management entities regarding the implementation of statewide expansion of the 1915(b)/(c) Medicaid Waiver. This law affects scattered provisions of Chapter 122C of the General Statutes.

Section 122C-115(a), which requires counties to provide mental health, developmental disabilities, and substance abuse services through an area authority or a county program, was rewritten so

that these services, which also fall under the 1915(b)/(c) Medicaid Waiver, must comply with the rules, policies, and guidelines adopted pursuant to statewide restructuring of management responsibilities. The bill also deleted from § 122C-115.1(i) a number of sections that previously exempted county programs, implying that those sections may now apply to county programs.

The area board, which governs the area authority, was also restructured by this law; previously, depending on whether the area board served a single county or a multicounty area, board membership was limited to a maximum 30 members. The amended law caps membership at 21 voting members. All multicounty area board members will now be appointed by those counties' boards of county commissioners, consistent with requirements provided in subsection (b) of § 122C-118.1 (see next paragraph) and with at least one member from each county. Failure to comply with these requirements will result in appointment by the Secretary. However, in multicounty areas with a catchment population greater than 1,250,000, the boards of county commissioners may unanimously adopt a resolution approved by the Secretary before January 1, 2013 to appoint members to the area board in a manner inconsistent with that required by this section. Finally, board members may now be removed if s/he fails to attend three consecutive meetings without a justifiable excuse.

Subsection (b) of § 122C-118.1 governs the composition of area board membership; now, boards must consist of, among others, a current county commissioner, an attorney with healthcare expertise, and an individual with financial expertise in managed care organizations. It is also important to note that area boards no longer require a physician member and that registered lobbyists are prohibited from membership in area authority boards. All area board members may be appointed for a maximum of three consecutive terms and must attend annual training.

By January 1, 2014, a procedure by which a single county may disengage from a multicounty area authority will be established. However, beginning July 1, 2012, and until July 1, 2014, all county requests to withdraw from a multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver will be denied.

The area authority may now single-handedly appoint an area director; the appointment is not subject to the approval of the board of county commissioners. The area authority can also borrow money with the approval of the Local Government Commission.

A new subsection added to § 122C-115.2 gives the Secretary of the North Carolina Department of Health and Human Services (DHHS) the discretion to waive any requirements of this Section ("LME business plan required; content, process, certification") that is inconsistent or incompatible with service contracts entered into between DHHS and the area authority.

The bill added a "Confidentiality of competitive health care information" section to General Statutes Chapter 122C. This new section excludes information relating to competitive health care activities by or on behalf of the area authority from public records. Contracts entered into by or on behalf of an area authority, however, shall be a public record unless otherwise exempted by law or contain competitive health care information. If an area authority receives a public records request and believes in good faith that the requested contract contains or constitutes competitive health care information, the authority may redact the sensitive portions or refuse disclosure. However, competitive health care information may be viewed by the Attorney General, the State Auditor, and elected officials in closed session.

Procedures concerning guardianship appointment for the Incompetent, § 35A-1213, were also amended; an individual who contracts with or is an employee of an entity that contracts with

North Carolina Medical Society
Leadership in Medicine

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The NCMS advocates for physicians and patients at the legislature and with managed care and regulatory organizations. This past year, the NCMS was at the forefront of battles regarding medical liability reform, Medicaid and State budget cuts, scope of practice issues and lobbying for a permanent solution to SGR.

ONLINE RESOURCES

The Medical Society has a rich online presence, with resources and tools to help you handle the latest issues such as tort reform, health information technology, ICD-10 implementation, end-of-life care, quality improvement, fraud and abuse defense and more. Take a look at www.ncmedsoc.org.

MEMBER RESOURCE CENTER (MRC)

The MRC fielded over 575 calls and e-mail inquiries last year, answering questions ranging from medical record retention to handling a RAC audit. Have a question? View the frequently asked questions or post your own question at www.ncmedsoc.org/mrc.

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PUBLICATIONS

The NCMS provides members with a weekly e-newsletter, the *Bulletin*, which includes the latest news on managed care, legislative actions, and more. Members also receive the North Carolina Medical Journal and discounts on magazines and coding publications through the NCMS Partners Guide.

a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services is prohibited from serving as a guardian for a ward for whom the individual or entity is providing these services. This prohibition does not apply to members of the ward's immediate family who are employees of an LME and are serving as a guardian as of January 1, 2013. This also does not apply to the ward's parents.

Finally, section 1(c) of S.L. 2011-264 was rewritten so that LMEs that have not been approved by DHHS to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013 must merge with or be aligned with an LME that has been approved. Failure to comply with this requirement or failure to meet performance requirements of an approved contract with DHHS to operate a 1915(b)/(c) Medicaid Waiver will result in DHHS forcibly assigning the noncompliant LME to an LME that is successfully operating the Waiver and has met the performance requirements of its contract.

MENTAL HEALTH CRISIS MANAGEMENT

Senate Bill 347

Sponsors: Purcell (D25), Bingham (R33), Mansfield (D21)
Status: 06/29/2012 – Chaptered Session Laws

Summary: This newly-enacted law, codified in § 122C-263.2 (Mental Health Crisis Management: Reasonable Safety and Containment Measures), allows acute care hospitals licensed under Chapter 131E, a department thereof, and other proper sites of first examination that do not operate as a licensable mental health facility to provide temporary sites for mental health patients prior to their involuntary commitment placement. These facilities are not to operate as 24-hour facilities, psychiatric substance abuse or special care units, mental health facilities, or offer any psychiatric or abuse services. However, these temporary providers may adopt certain reasonable safety and containment measures, such as altering rooms, removing items to prevent injury, and placing patients in a consolidated hospital area.

The bill also proposes a statewide study on local management entities' efforts to reduce acute care inpatient admissions for patients with primary diagnoses of mental, developmental, or substance abuse disorders and to reduce the number of patients requiring three or more episodes of crises service. The Department of Health and Human Services is to report its finding to the General Assembly during the 2013 session.

CRITICAL ACCESS BEHAVIOR HEALTH AGENCIES

Senate Bill 525

Sponsors: Tucker (R35), Hartsell (R36)
Status: 07/12/2012 – Chaptered Session Laws

Summary: Senate Bill 525 makes Critical Access Behavioral Health Agencies (CABHAs) the sole providers of three Medicaid services: Community Support Team, Intensive In-Home, and Child and Adolescent Day Treatment. Each CABHA also is required to provide comprehensive clinical assessment, medication management, outpatient therapy, and at least two additional services from a list of 14 services enumerated in Section 2 of the Law. Staffing at CABHAs must include a North Carolina-licensed doctor in good standing with the Division of Medical Assistance, a clinical director, and a quality management/training director with training or experience in quality management or training.

NOTES

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