SENATE BILL 361:
Health Care Expansion Act of 2019.

2019-2020 General Assembly

Committee:	House Health. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	August 2, 2019
Introduced by:	Sens. Krawiec, Bishop, Hise	**Prepared by:**	Jessica Boney
Analysis of:	PCS to Third Edition S361-CSBC-76		Theresa Matula Jason Moran-Bates Committee Staff

OVERVIEW: The Proposed Committee Substitute to Senate Bill 86 would (1) enact the Psychology Interjurisdictional Licensure Compact (PSYPACT), (2) allow marriage and family therapists to conduct the first-level exam for involuntary commitment, (3) eliminate redundancy in adult care home inspections, (4) create the Lupus Advisory Committee, (5) modify step therapy protocols, (6) provide equal coverage for oral chemotherapy drugs, (7) amend telehealth coverage provisions for Medicaid and private insurance, and (8) establish a task force to develop innovative solutions to the problems with access to healthcare in North Carolina.

BILL ANALYSIS:

PART I. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT (PSYPACT)
Part I would create enact the Psychology Interjurisdictional Compact and make North Carolina a member of the Compact.

Section 1.(a) would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18H of Chapter 90 of the General Statutes.

Section 1.(b) of the bill would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

G.S. 90-270.162 would:

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.
    - Investigate complaints against psychologists.
    - Notify the PSYPACT Commission about adverse actions taken against psychologists.
    - Comply with the by-laws of the Commission.
    - Perform criminal background checks on psychologists.
- Allow a psychologist to provide face-to-face services in a compact state if that state:

- Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
- Investigates complaints against psychologists.
- Notifies the PSYPACT Commission about adverse actions taken against psychologists.
- Complies with the by-laws of the Commission.
- Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

Part I would become effective when at least seven states have enacted the PSYPACT.

PART II. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAM FOR INVOLUNTARY COMMITMENT

Part II would amend G.S. 122C-263.1 to permit licensed marriage and family therapists to conduct first examinations in involuntary commitment proceedings.

Part II would be effective October 1, 2013.

PART III. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

Part III would amend the statute pertaining to inspections, monitoring, and review of adult care homes. This part would provide that if the annual inspection of an adult care home is conducted separately from the physical plant and life-safety requirements inspection required every two years, the Division of Health Service Regulation, DHHS, is prohibited from citing a violation of law that overlaps with a physical plant and life-safety inspection area in the annual inspection unless failure to address poses a risk to resident health or safety.

PART IV. RAISE LUPUS AWARENESS

Part IV would designate May as Lupus Awareness Month and create the Lupus Advisory Council.

PART V. STEP THERAPY PROTOCOLS

Part V would establish step therapy protocols for private insurers and the State Health Plan for Teachers and State Employees.

Part V would require insurers to develop their formularies with the approval of a therapeutics committee that complies with standards established by the Center for Medicare and Medicaid Services. These formularies would have to be made available to providers, pharmacists, and insureds and updated after a review of new research. Insurers must grant exception requests to the formulary drugs and cover an alternate drug if an insured can demonstrate any of the following:

- The insured has tried the alternate drug while covered by the current or the previous health benefit plan.
- The formulary drug has been ineffective in the treatment of the insured's condition.
- The formulary drug is reasonably expected to cause a harmful or adverse clinical reaction in the insured.
- Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug, or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.
- The insured's physician certifies in writing that the insured has previously used an alternative drug or device and the alternative drug or device has been detrimental to the enrollee's health.

Part V would be effective October 1, 2019, and apply to insurance contracts issued, renewed, or amended on or after that date.

PART VI. CANCER TREATMENT FAIRNESS

Part VI would require insurers to cover orally-administered chemotherapy drugs on the same terms as intravenous or injected chemotherapy drugs.

Part VI would require insurers who offer coverage for oral chemotherapy and intravenous or injected chemotherapy drugs to provide coverage for oral chemotherapy drugs on terms no less favorable than those for intravenous or injected chemotherapy drugs. Insurers would be prohibited from subjecting oral chemotherapy drugs to any pre-authorization, coverage limit, co-payment, coinsurance, or deductible that did not apply to intravenous or injected chemotherapy drugs.

It would also prohibit insurers from complying with the new rules by reclassifying anticancer drugs or increasing a patient's cost-sharing on any anticancer drugs. Any policy change that would result in an increase in a patient's out-of-pocket expense for anticancer drugs would also have to be applied to the majority of the other pharmaceutical or medical benefits provided by the policy.

Part VI would be effective January 1, 2020, and apply to insurance contracts or policies issued, renewed, or amended on or after that date. It would not become effective if it is found to create a new state-required benefit under 45 C.F.R. 155.170(a)(3).

PART VII. MODERNIZE MEDICAID TELEMEDICINE POLICIES

Part VII would require the Department of Health and Human Services to make changes to the telemedicine and telepsychiatry policies for Medicaid and NC Health Choice.

Part VII would require DHHS to make changes to the Medicaid and NC Health Choice Clinical Coverage Policy for Telemedicine and Telepsychiatry including the following:

- Reimbursement for telemedicine and telepsychiatry services performed in a recipient's home or delivered from a licensed practitioner's home.
- No required referral for the use of telemedicine or telepsychiatry services.
- Coverage for delivery of telemedicine or telepsychiatry over the phone or by video cell phone.

- Allowing a referring provider and a receiving provider to bill for facility fees related to the provision of telemedicine or telepsychiatry on the same date of service.
- Telemedicine and telepsychiatry services must not be subject to the exact same restrictions as face-to-face contacts. The clinical coverage policy must be updated to align the policy with best practices for telemedicine and telepsychiatry.
- All behavioral health providers who are directly enrolled as providers in the Medicaid and NC Health Choice programs must be included in the coverage policy as providers who may bill for facility fee, including: licensed professional counselors, licensed marriage and family therapists, certified clinical supervisors, and licensed clinical addictions specialists.

The Department would be further directed 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 expanded billing codes shall not include group-type therapies.

Department must submit to the Centers for Medicare and Medicaid Services any waivers or amendments to the NC Medicaid State Plan necessary to implement the act and the changes will be effective following completion of the process in G.S. 108A-54.2.

PART VIII. INCREASE ACCESS TO TELEHEALTH SERVICES

Part VIII would require Medicaid and NC Health Choice promote access to care through telehealth services and establish guidelines for providing those services. It would also require private health insurance and the State Health Plan to provide coverage for telehealth services on terms equivalent to those for coverage of in-person services and prevent private health insurance and the State Health Plan from excluding services from coverage solely because they were provided via telehealth

Part VIII would require DHHS to ensure that coverage of telehealth and telepsychiatry services by Medicaid or NC Health Choice are consistent with this section and to amend Clinical Coverage Policy 1H if necessary. DHHS would also be required to:

- Promote telehealth for Medicaid and NC Health Choice recipients.
- Require prior authorization requests for specialty care to be processed by the patient's primary care provider.
- Require all Medicaid providers who provide healthcare services to be licensed to provide those services.
- Require facilities that provide telehealth services to protect patient confidentiality.
- Submit the necessary waivers to implement this act.
- Report to the Joint Legislative Medicaid and NC Health Choice Oversight Committee and the Fiscal Research Division on expected changes, costs, savings, and outcomes.

DHHS could not require healthcare providers to:

- Be physically present with the patient, unless necessary.
- Conduct a telehealth consultation if an in-person consultation is reasonably available.
- Require a prior authorization for a telehealth consultation if it would not be required for an in-person consultation.
- Be part of a telehealth network.

Part VIII would also define "telehealth" to include (i) encounters through real-time audio and video technology, (ii) asynchronous store-and-forward services, or (iii) any asynchronous communication where the healthcare provider has access to the patient's history prior to initiating the encounter and require Medicaid and NC Health Choice to provide coverage and reimbursement for telehealth on the same terms as they do for in-person services.
Part VIII would become effective October 1, 2019. Section 9 of the act would apply to health benefit plan contracts issued, renewed, or amended on or after that date.

PART IX. NORTH CAROLINA HEALTHCARE TASK FORCE
Part IX would create the North Carolina Healthcare Solutions Task Force, a 10-year ongoing study designed to identify innovative solutions to problems with access to healthcare in the state.

Part IX would create the North Carolina Healthcare Solutions Task Force (Task Force), which would be supported by the North Carolina Area Health Education Centers Program (AHEC). The Task Force would be comprised of six members appointed by the General Assembly, three members from the AHEC, and two members each from the Cecil G. Sheps Center, the North Carolina Institute of Medicine, and the Office of Rural Health.

The Task Force's work would be split into two stages. Stage One culminates in a report submitted to the Joint Legislative Oversight Committee on Health and Human Services, no later than April 1, 2021. The report must include:

- Metrics designed to provide an accurate assessment of the current state of access to healthcare in North Carolina.
- Identification of data and data sources necessary to provide an accurate assessment of the current state of access to healthcare in North Carolina.
- Examination of reimbursement rates offered by, and other factors pertaining to, Medicaid, NC Health Choice, and the State Health Plan for Teachers and State Employees and how those rates and other factors affect (i) the numbers of providers choosing to participate in the programs and (ii) access to healthcare for the beneficiaries of those programs.
- Examination of the provider reimbursement rates for Medicaid services provided through the Community Alternatives Program for Disabled Adults (CAP/DA) waiver to determine (i) the adequacy of the rates to ensure access to these services and (ii) whether adjustments to the CAP/DA waiver would be needed to ensure that CAP/DA beneficiaries do not lose access to services as a result of any provider rate increase.
- Examination of the state of graduate medical education, access to clinical rotations for physician assistants, and the distribution of community preceptors.
- Any other issues the Task Force deems necessary to properly measure and assess the state of access to healthcare in North Carolina.

In Stage Two, the Task Force would be required to:

- Report on the current state of access to healthcare in North Carolina, based on the metrics and data identified in Stage One.
- Identify and report on innovative solutions to address issues preventing greater access to healthcare in North Carolina.
- Examine at least the following:
    - The impact of short-term doctor exchange or visitation programs on access to healthcare.

  - The feasibility of offering tax credits or other financial incentives to medical providers in order increase the number of healthcare providers in the State.
  - Innovative measures implemented by other states that are designed to increase access to healthcare.
  - Whether the direct primary care model of payment would increase preventative health services, improve health outcomes, and lower the overall cost of care.
  - The extent to which new models of healthcare and payment are being adopted in North Carolina and the effects of those models on access to healthcare in the State.
  - Any other healthcare access issues the Task Force deems appropriate.
- Report on the impact previous years' recommendations have had on the current state of access to healthcare in North Carolina and any other areas of examination the Task Force deems appropriate.

The Task Force must submit an initial report on its Stage Two activities no later than April 1, 2022. Updated reports must be submitted annually thereafter, and the Task Force would terminate after submitting a final report in 2030.

PART X. SEVERABILITY CLAUSE
Part X would allow the remainder of the act to remain in effect even if one portion of it is deemed unconstitutional or invalid.

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