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Health

During the 2005 session, the General Assembly enacted more than sixty bills and budget special provisions affecting public health, government health insurance, health care facilities, and the health care professions.

The Current Operations and Capital Improvements Appropriations Act of 2005, S.L. 2005-276 (S 622), provides funding for a number of public health initiatives, including fifty new school nurse positions, grants for community-based programs to eliminate disparities in health status between majority and minority populations, and a pilot program to pay for interpreter services for local health department patients who do not speak English proficiently.

A special provision in the appropriations act transfers children under age six from North Carolina Health Choice, the state children's health insurance program, to the Medicaid program. Other special provisions create the Medicaid Ticket to Work program and establish new criteria for how Medicaid applicants may provide evidence of their North Carolina residency.

A new law will require local health departments to obtain and maintain accreditation. Local authority to regulate smoking in public places has been expanded, and smoking inside buildings operated by the Department of Correction (DOC) has been prohibited. The tax on cigarettes increased from 5 cents to 30 cents per pack on September 1, 2005, and will rise to 35 cents per pack on July 1, 2006.

The legislature was quite active in the area of school health. A new law requires local boards of education to adopt policies permitting students with asthma or life-threatening allergies to carry and self-administer medications. Another law regulates snacks and beverages in school vending machines. Special provisions in the appropriations act enact a new law requiring all students enrolling in public kindergarten to obtain a comprehensive eye examination and establish the Governor's Vision Care Program to provide funds for early detection and correction of vision problems in children.

The 2005 General Assembly provided for the licensure of perfusionists, the health care personnel who operate heart and lung machines. Several other new laws amend other licensure acts, including those applying to acupuncturists, recreational therapists, and occupational therapists.

Two enacted bills make changes to the state's certificate of need law that are the most significant the health care industry has experienced in over a decade. More than a dozen other new laws or special provisions that are not specifically directed to public health or health care nevertheless will be of interest to health professionals. They include the Identity Theft Protection Act and the Methamphetamine Lab Prevention Act.

These and several other new laws are summarized in this chapter. Other chapters that summarize laws that may be of interest to public health or health care professionals include Chapter 4, “Children, Families, and Juvenile Law”; Chapter 11, “Environment and Natural Resources”; Chapter 16, “Mental Health”; Chapter 22, “Senior Citizens”; and Chapter 23, “Social Services.”

Public Health

Budget

The 2005 appropriations act, S.L. 2005-276, provides funding for a number of new and continuing public health programs. The act allocates \$2 million in nonrecurring funds for the Community-Focused Eliminating Health Disparities Initiative. This program will provide grants to community-based organizations, including faith-based organizations. Grant recipients must use the funds to develop programs focused on reducing certain health problems in minority communities, including infant mortality, HIV/AIDS, sexually transmitted diseases, cancer, diabetes, homicides, and motor vehicle-related deaths.

In 2004 the General Assembly created the School Health Nurse Initiative and appropriated \$4 million in recurring funds to pay for eighty school nurse positions across the state (S.L. 2004-124). The 2005 appropriations act provides an additional \$2.5 million in recurring funds to continue this effort and pay for fifty additional permanent school nurse positions.¹

The act appropriates a little more than \$4 million in nonrecurring funds to the North Carolina Division of Public Health to develop and implement the Health Information System, an automated data system for monitoring, reporting, and billing services provided in local health departments, children’s developmental services agencies, and the state public health lab. The system is intended to replace the Health Services Information System that is currently in use.

S.L. 2005-276 provides a substantial amount of nonrecurring funding to automate the state’s vital records system. The Office of Vital Records will receive \$100,000 in fiscal year 2005–06 and \$1.4 million in fiscal year 2006–07 to carry out this effort. The act also appropriates about \$75,000 in recurring funds to establish two new staff positions to process vital records.

Section 10.9 of S.L. 2005-276 provides that \$2 million of the recurring funds appropriated for community health grants must be used for federally qualified health centers, rural health centers, local health departments, and other community health centers to

1. increase access to preventive and primary care by uninsured or medically indigent patients in existing or new health centers;
2. establish community health center services in counties without these services;
3. create new services or augment existing services for uninsured or medically indigent patients, including primary care and preventive services and dental, pharmacy, and behavioral health services; and
4. increase capacity to serve the uninsured by enhancing or replacing facilities, equipment, or technologies.

Section 10.57 of the appropriations act directs the North Carolina Division of Public Health to develop a pilot program to place automated external defibrillators (AEDs) in public buildings, including public gymnasiums. The division must use \$17,000 of the funds appropriated to it for 2005–06 and \$6,000 of the funds appropriated for 2006–07 to purchase AED units, conduct training in their use at the pilot sites, and provide ongoing education and awareness campaigns for the general public.

Other key public health initiatives that received appropriations in 2005 include

- \$700,000 in recurring funds to provide staff and other resources for a new local health department accreditation program (described below).

1. For additional information about the use of these funds, see the section on “School Health,” later in this chapter.

- \$2 million in recurring funds to pay for a model program to provide eye examinations for needy children in child care centers and preschools. This program is linked to the new kindergarten comprehensive eye examination program, described below in the section on school health.
- \$5 million in recurring funds for the provision of services under the state's early intervention program. Section 10.54A of the 2005 appropriations act enacts G.S. 130A-126, which transfers rule-making authority for the birth to three-year-old early intervention program from the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to the Commission for Health Services. Another special provision, Section 10.54, requires the North Carolina Division of Public Health to evaluate and report on early intervention services. The report must analyze the funding for the children with special needs program and develop a plan to use those funds within the early intervention program.
- A \$1 million increase in recurring funds for the AIDS Drug Assistance Program, a program that pays for prescription drugs to treat individuals with HIV or AIDS who have family incomes at or below 125 percent of the federal poverty guidelines. A special provision, Section 10.59, prohibits the Department of Health and Human Services (DHHS) from extending eligibility for the program to individuals with incomes above 125 percent of the federal poverty guidelines during the 2005–07 fiscal biennium.
- \$250,000 in recurring funds for a pilot program to pay for interpreter services in local health departments. Local health departments are required by federal civil rights laws to provide interpretation services to their limited-English proficient clients, and they are prohibited by the same laws from charging the clients for the services.
- \$1 million in recurring funds for continued support of North Carolina's public health incubators. The public health incubator program was established by the 2004 appropriations act (S.L. 2004-124) to promote collaboration among local health departments and build capacity in the state's public health system.²
- \$100,000 in recurring funds for the Healthy Carolinians program. The act also provides \$400,000 in nonrecurring funds for the program for fiscal year 2005–06.

The 2005 appropriations act reduces the state appropriation for the State Public Health Laboratory by about \$370,000 in the expectation that the reduction will be offset by an increase in the fee for required newborn screening tests. On September 1, 2005, the fee rose from \$10 to \$14.

The 2005 appropriations act did not reduce funding for chronic disease prevention activities, but a special provision, Section 10.56, appears to signal that cuts may be forthcoming. Section 10.56 directs DHHS to inventory all chronic disease prevention activities, funding, staffing, and other resources "in order to reduce costs and eliminate duplication of effort." The inventory must include programs in heart disease, stroke, diabetes, osteoporosis, and cancer. In addition, DHHS must create a plan to combine task forces and activities for chronic disease prevention and explore collapsing those activities into the Healthy Carolinians structure.

Local Health Department Accreditation

In late 2003 Secretary of Health and Human Services Carmen Hooker Odom convened the Public Health Task Force 2004 and charged it with developing recommendations for improving North Carolina's public health infrastructure, improving the health status of North Carolinians, and eliminating disparities in health status between the majority population and minority groups. From the outset, one of the task force's goals was to implement a statewide system for accrediting local health departments in North Carolina, building on a pilot accreditation program that had been underway for

2. The 2004 appropriations act appropriated \$1 million in nonrecurring funds to the North Carolina Institute for Public Health to establish the incubator program. The institute then allocated funds to four incubators: the Northeastern North Carolina Partnership for Public Health (composed of ten local health departments serving nineteen counties), the South Central Incubator (composed of eight local health departments serving eight counties), the Western Incubator (composed of thirteen local health departments serving seventeen counties), and the Region III Northwest Incubator (composed of eight local health departments serving ten counties).

several years. When the task force released its final report in January 2005, one of its key recommendations was to establish a mandatory accreditation system for all local health departments in North Carolina.³

That recommendation was carried out in S.L. 2005-369 (S 804). This law enacts new G.S. 130A-34.1, which requires all local health departments in North Carolina to obtain and maintain accreditation. The initial accreditation of local health departments is to be implemented over a period of eight years, beginning January 1, 2006.

The new law creates the Local Health Department Accreditation Board within the North Carolina Institute for Public Health (a unit of the University of North Carolina at Chapel Hill School of Public Health). The Accreditation Board will be composed of seventeen members appointed by the Secretary of Health and Human Services, including county commissioners, local board of health members, local health directors, and staff members of the state Divisions of Public Health and Environmental Health. It will be responsible for developing a schedule by which local health departments must apply for initial accreditation, reviewing each department's application for accreditation, and assigning each department a status as follows:

- "Accredited" means the department has satisfied the standards for accreditation. Accreditation expires after four years and the department must apply for re-accreditation.
- "Conditionally accredited" means the department has failed to meet one or more of the standards for accreditation and has been granted short-term accreditation status that is subject to conditions set by the board. This status is good for two years. By the end of that time, the department must have satisfied the board's conditions and met the criteria for accredited status, or it will become unaccredited.
- "Unaccredited" means the department has continued to fail to meet one or more of the standards after a period of conditional accreditation.

Finally, the new law authorizes the Commission for Health Services to adopt accreditation standards and rules for the accreditation process, which must include a health department self-assessment and a site visit. The commission must also adopt rules for informal procedures for review of Accreditation Board decisions.

Smoking Regulation and Cigarette Tax

Article 64 of G.S. Chapter 143 regulates smoking in public places in North Carolina. When it enacted this law in 1993, the General Assembly expressed the intent to "address the needs of both smokers and nonsmokers" by providing that public places contain both smoking and nonsmoking areas.⁴ Article 64 requires at least 20 percent of the interior space of public buildings to be designated as a smoking area, unless to do so is physically impracticable. Local governments were permitted to enact more stringent local regulations until October 15, 1993, but local rules or ordinances enacted after that date must provide for a smoking area in most local government buildings, indoor arenas, and other public places. However, G.S. 143-599 provides a list of facilities that are exempt from the provisions of Article 64 and in which smoking may be prohibited entirely.

The list of exemptions in G.S. 143-599 has always included local health departments. However, while it was clear that local health departments could prohibit smoking in all of the health department's interior spaces, it was unclear whether the prohibition could extend to the health department's grounds. It was also unclear whether smoking could be prohibited throughout a building containing a health department when the building also contained another government agency that was not on the exemption list, such as a department of social services. S.L. 2005-19 (H 239) clarifies these two issues. It amends G.S. 143-599 to specify that the exemptions include the local health department and the building and grounds where it is located. S.L. 2005-168 (H 1482), enacted later in the session, further amends the same subsection to add the local department of social services and the buildings and

3. North Carolina Department of Health and Human Services, *North Carolina Public Health Improvement Plan: Final Report* (January 15, 2005) (available on the Internet <http://www.ncpublichealth.com/taskforce/docs/FinalReport1.15.05.pdf>).

4. S.L. 1993-367, sec. 1 (codified at G.S. 143-595).

grounds where it is located to the exemption list. “Grounds” is defined to mean the area located within fifty linear feet of a local health department or a local department of social services.

S.L. 2005-239 (S 482) amends the list of exemptions in G.S. 143-599 to include indoor arenas with a seating capacity of greater than 23,000.

S.L. 2005-372 (S 1130) regulates smoking and other tobacco use in buildings that are part of a state correctional institution. New G.S. 148-23.1 prohibits the use of tobacco products in state correctional institution buildings by inmates, employees, and visitors, effective January 1, 2006. The prohibition extends to chewing tobacco and snuff, as well as cigarettes and cigars. The new law applies only to facilities operated by the Department of Correction and therefore does not extend to local jails. Furthermore, it addresses only the use of tobacco products inside buildings—it does not extend to facility grounds. However, an uncodified provision of the law authorizes DOC to conduct one or more pilot programs banning smoking on facility grounds as well. If DOC conducts such a pilot, it must offer inmates and staff of the facility an opportunity to participate in a smoking cessation program, but no person may be required or coerced to participate. Finally, S.L. 2005-372 adds state correctional facilities operated by DOC to the list of facilities exempt from the provisions of G.S. Chapter 143, Article 64.

A significant increase in the tax on cigarettes was included in the 2005 appropriations act. Section 34.1 of S.L. 2005-276 increased the tax to 1.5 cents per cigarette, or 30 cents per pack, effective September 1, 2005. On July 1, 2006, the tax will increase to 1.75 cents per cigarette, or 35 cents per pack. Section 34.1 also increased the tax on other tobacco products from 2 percent to 3 percent of the wholesale price.

School Health

There was significant legislative activity in the area of school health this year. New laws

- require local boards of education to adopt policies authorizing students who have asthma or life-threatening allergic reactions to possess and self-administer medication,
- regulate food products sold in school vending machines,
- require new statewide standards for school nutrition programs, and
- establish a comprehensive eye examination requirement for students enrolling in public kindergarten.

S.L. 2005-22 (H 496) requires local boards of education to adopt policies authorizing students who have asthma or who are subject to anaphylactic allergic reactions to possess and self-administer medication during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events. The policies must include a requirement that parents provide the school with several documents:

- Written permission for the student to possess and self-administer the medication.
- A written statement from the student’s health care provider verifying the student’s diagnosis and prescription for medication that may be needed during school or school-related activities. The health care provider’s statement must affirm that the student has been instructed in self-administration of medication and has the skills necessary to use the medication and any device required to administer it.
- A written treatment plan and emergency protocol formulated by the health care provider who prescribed the medication.
- A signed statement acknowledging that the school is not liable for an injury arising from a student’s possession and self-administration of medication.

Local policies must also require the student to demonstrate to the school nurse or the nurse’s designee the student’s ability to self-administer the medication. The student’s parent or guardian must provide back-up medication to the school to be kept in a location where the student will have immediate access in the event of an emergency. If a student uses the medication for a purpose other than that for which it was prescribed, he or she may be subject to discipline in accordance with a school’s disciplinary policy, but the disciplinary measures may not limit or restrict the student’s immediate access to the medication. Finally, the new law provides qualified immunity from liability for local boards of education and their members, employees, designees, and agents for any act

authorized by the new law or any omission related to it. S.L. 2005-22 was enacted in April 2005 and is in effect for the 2005–06 school year.

Two new laws are directed at improving the nutritional value of foods and beverages sold in schools. S.L. 2005-253 (S 961) regulates the sale of products sold in school vending machines. Since 1992, G.S. 115C-264 has permitted schools, with local board of education approval, to use vending machines to sell soft drinks to students, as long as the drinks were not sold (1) during breakfast or lunch times, (2) to elementary students, or (3) contrary to the requirements of the National School Lunch Program. S.L. 2005-253 deletes the provisions addressing soft drink vending from G.S. 115C-264 and reenacts them in a new section, G.S. 115C-264.2, which governs all snack and beverage vending machines in schools. Under the new law, any vending contracts executed or renewed after August 1, 2005, must provide that sugared carbonated soft drinks will not comprise more than 50 percent of the offerings for sale to students in high schools, and they may no longer be sold in middle schools at all. Furthermore, bottled water products must be available in every school that offers beverage vending. Finally, by the 2006–07 school year, snack vending in all schools must meet the “proficient” level of the North Carolina Eat Smart nutrition standards. The proficient level requires that there be no snack vending in elementary schools, and that 75 percent of the snack vending products in middle and high schools contain 200 calories or less.

Another law, S.L. 2005-457 (H 855), directs the State Board of Education to develop statewide standards for school meals, à la carte foods and beverages, and items served in after-school programs and local education agencies’ child nutrition programs. The standards must promote gradual changes to increase the availability of fruits, vegetables, and whole-grain products and decrease foods that are high in fat or sugar.

A special provision in the 2005 appropriations act enacts new G.S. 130A-440.1, which will require each child entering kindergarten in the state’s public schools to have an eye examination. Beginning with the 2006–07 school year, each child enrolling in kindergarten in a public school must present proof of a comprehensive eye examination by an ophthalmologist or optometrist. If a child has moved to North Carolina within the sixty days immediately preceding school entry, the child will be given sixty days after school entry to obtain the examination. The new law does not apply to children enrolling in kindergarten in private church schools, schools of religious charter, or qualified nonpublic schools.

Another special provision in S.L. 2005-276 establishes the Governor’s Vision Care Program, which will provide funds for early detection and correction of vision problems in children enrolled in kindergarten through third grade. Children will be eligible for the program if they have a family income that is less than 250 percent of the federal poverty guidelines, do not have private health insurance, and are not eligible for services under North Carolina Health Choice, Medicaid, or programs operated by the Commission for the Blind, VSP’s Sight for Students program, or the Lions Club foundation. Funds appropriated to the program will be used to reimburse providers for conducting the comprehensive eye examinations required by new G.S. 130A-440.1 and for providing eyeglasses.

Section 10.40D(f) of the 2005 appropriations act gives local boards of education the authority to adopt policies and procedures authorizing schools to use unlicensed personnel to administer medications to students. If a local board chooses to exercise this authority, its policies and procedures must address training and competency evaluations of the unlicensed personnel, requirements for listing the personnel in the medication aide registry established by new G.S. 131E-270,⁵ and requirements for supervision of medication aides by licensed health professionals or qualified supervisory personnel.

Another special provision in the 2005 appropriations act establishes the School-Based Child and Family Team Initiative to identify and coordinate community services for children at risk of school failure or out-of-home placement. Section 6.24 of S.L. 2005-276 has a stated goal of increasing schools’ capacity to address academic, health, mental health, social, and legal needs of school children. The provision requires local health directors to serve on a local advisory committee for the initiative

5. This special provision actually refers to the medication aide registry established in G.S. 131E-271, but the citation is incorrect. The medication aide registry was established by another special provision, Section 10.40C(c), and codified as G.S. 131E-270. The new legislation regarding medication aides is discussed later in this chapter, under “Health Care Professions,” “Medication Aides.”

and local health departments to take the lead role in assisting children and families whose primary needs are health related.

Section 10.53 of the 2005 appropriations act provides \$2.5 million to pay for fifty additional permanent school nurse positions. The Division of Public Health will distribute the school nurse funds in conjunction with the Department of Public Instruction. The agencies must determine which areas have the greatest need for school nurses and the greatest inability to pay for them. The agencies must also consider local nurse-to-student ratios, economic status, and health needs of children. A nonsupplant clause requires communities to maintain their current level of effort and funding for school nurses. School nurses funded through this appropriation are required to participate as needed in the School-Based Child and Family Team Initiative.

The General Assembly did not enact House Bill 865, a bill that would have required local boards of education to adopt policies requiring physical activity for elementary and middle school children, but a State Board of Education policy adopted in April 2005 achieved the same effect. The board's policy number HSP-S-000 requires schools to provide students in kindergarten through eighth grade with thirty minutes of moderate to vigorous physical activity each school day. The requirement can be achieved through regular physical education classes or other activities such as recess or classroom energizers. Schools must fully implement the physical activity requirement by the 2006–07 school year.

Finally, Section 10.59G of S.L. 2005-276 authorizes the Legislative Research Commission to study and evaluate school-based and school-linked health centers in North Carolina.

Environmental Health

In the fall of 2004, North Carolina experienced an outbreak of *E. coli* that was eventually traced to a petting zoo exhibited at the 2004 state fair. The outbreak caused more than 100 cases of diarrheal illness, primarily in young children. Some of the children developed hemolytic uremic syndrome, a life-threatening complication of *E. coli* that can require long-term hospitalization and produce lasting health effects. The General Assembly responded to the outbreak by enacting S.L. 2005-191 (S 268), which was named "Aedin's Law" for one of the children who became seriously ill. The new law regulates animal exhibitions, defined to include agricultural fairs where animals are displayed for physical contact with humans. The law requires animal exhibitions to be inspected and permitted by the Commissioner of Agriculture. The commissioner is authorized to adopt rules, with the advice and approval of the State Board of Agriculture and in consultation with the North Carolina Division of Public Health. Among other things, the rules must include requirements for hand-washing facilities in animal exhibitions, animal care and management, and education and signs addressing health and safety issues. In the event the rules are violated, the commissioner is authorized to revoke an operator's permit and to assess a civil penalty of up to \$5,000. The law became effective October 1, 2005.

Part IV of S.L. 2005-386 (H 1096) amends the inspection schedule for food service establishments that is set forth in G.S. 130A-249.⁶ The former law required quarterly inspections of restaurants, except for temporary establishments. The new law directs the Commission for Health Services to establish a schedule for inspections of food service establishments. It requires the commission to take into account the risks to the population served by the establishment and the type of food and drink served by the establishment. The new schedule and implementing rules must be adopted by November 1, 2007.

A bill that public health officials monitored closely but that did not pass during the 2005 session was House Bill 900.⁷ Under present law, only a local health department may evaluate a proposed development site and issue an improvement permit authorizing the construction of an on-site wastewater system. House Bill 900 would have authorized private licensed soil scientists or professional engineers to perform this function. It also would have provided that if an improvement permit application that was based on the evaluation of a licensed soil scientist or both a licensed soil

6. S.L. 2005-386 amends a number of the state's environmental laws, but only Part IV is summarized in this chapter. For additional information about the new law, see Chapter 11, "Environment and Natural Resources."

7. An identical bill was introduced in the Senate (S 902). The Senate did not act on the bill during the 2005 session.

scientist and a professional engineer was not acted upon by a local health department within ten days, the site would be deemed permitted. The bill did not pass either chamber of the General Assembly during the legislative session, but the issue is expected to resurface in future sessions.

Public Health Authorities

In 1997 the General Assembly enacted a law that authorized counties to provide public health services through a single- or multi-county public health authority, rather than a traditional local health department.⁸ Public health authority boards have different membership requirements than traditional boards of health and also have expanded powers and duties.

The 2005 General Assembly enacted two laws that affect the powers of public health authorities. S.L. 2005-326 (S 682) amends G.S. 105A-2(6) to add public health authorities to the list of local agencies that are permitted to use the set-off debt collection procedures that are currently available to North Carolina cities and counties.

S.L. 2005-459 (S 665) authorizes certain public health authorities to expand their board membership. Public health authority boards ordinarily may have no more than nine members for a single-county authority or eleven members for a multi-county authority. The new law amends G.S. 130A-45.1 to authorize public health authority boards that intend to pursue federally qualified health center status (or look-alike status) to have between nine and twenty-five members. S.L. 2005-459 also enacts new G.S. 130A-45.13, which authorizes public health authority boards to contract with private vendors to operate the authority's Medicaid billing system, permitting the authority to bypass the state's health services information system (HSIS) and bill Medicaid directly. However, any system used by a public health authority must still have the ability to interface with state public health data systems.

Government Health Insurance

Medicaid

The 2005 General Assembly considered a number of alternatives for reducing eligibility or services under the Medicaid program. In the end, there was no major overhaul of Medicaid, but several significant changes to the program were enacted by the 2005 appropriations act.

One of the most significant changes was the transfer of children under the age of six from the state children's health insurance program (North Carolina Health Choice) to the Medicaid program. In the past, infants under the age of one have been eligible for Medicaid if their family income was at or below 185 percent of the federal poverty guidelines (FPG), and children between the ages of one and five have been eligible for Medicaid if their family income was at or below 133 percent FPG. Children in each age group whose family incomes were higher than those limits but at or below 200 percent FPG have not been eligible for Medicaid but have been eligible for Health Choice. Section 10.11(m) of the 2005 appropriations act provides that children under the age of six in families with incomes of up to 200 percent FPG will be eligible for Medicaid, effective January 1, 2006. Section 10.22 amends G.S. 108A-70.21 to reflect this change.

Section 10.18 of the 2005 appropriations act enacts the Health Coverage for Workers with Disabilities Act, also known as the Medicaid Ticket to Work program, and appropriates \$150,000 in recurring funds to support it, beginning July 1, 2006. The purpose of the new program is to allow low-income workers with disabilities to buy health insurance through the Medicaid program. A new statute, G.S. 108A-54.1, establishes the eligibility criteria for the program.

To be eligible to receive Medicaid in North Carolina, an applicant must be a resident of the state. A new statute, G.S. 108A-55.3, requires applicants to provide "satisfactory proof" of their residency by providing at least two documents from a specified list. If an applicant declares under penalty of perjury

8. S.L. 1997-502.

that he or she does not have two of the specified documents, other credible evidence of residency may be considered. Furthermore, applicants for emergency Medicaid will not be required to provide the documents. For emergency Medicaid applicants, a declaration, affidavit, or other statement from the applicant's employer, clergy, or another person with personal knowledge of the applicant's residency will be sufficient. Finally, the satisfactory proof requirement does not apply to a Medicaid applicant who qualifies for an exception from state residency requirements under federal law.

The 2005 appropriations act also makes the following changes to the Medicaid program:

- Freezes Medicaid provider reimbursement rates at 2004–05 amounts, meaning the reimbursement rates cannot be increased during fiscal year 2005–06 (however, the rates may be decreased).
- Provides \$1.7 million in recurring funding for personal care services for residents of adult care home special care units, beginning October 1, 2006. At the same time, the act reduces funding for personal care services by \$13.7 million in fiscal year 2005–06 and \$16.1 million in 2006–07. Section 10.19(a) specifies that the Division of Medical Assistance must accomplish this reduction by implementing a utilization management system for personal care services that may include reducing personal care service hours or otherwise managing the services.
- Provides \$2 million in recurring funding to increase Medicaid reimbursement rates for dental services.
- Increases to \$3.00 the required co-payment for generic prescription drugs and for the following health care services: chiropractic, optical, podiatry, hospital outpatient, and nonemergency visits to hospital emergency departments. The increase was effective October 1, 2005.
- Decreases recurring funding to the Division of Medical Assistance by \$2.7 million in fiscal year –5-06 and \$6.7 million in fiscal year 2006–07, in the expectation that the decrease will be offset by the use of drug utilization management measures. Such measures may include requirements for pre-authorization or reviews for particular drugs or limitations on drugs, drug classes, brands, or quantities. However, the Division of Medical Assistance is prohibited from imposing prior authorization requirements on certain categories of medications and may not limit the use of brand-name medications when the health care provider who prescribes the brand-name medication specifies that it is medically necessary.
- Decreases state funding to account for the Medicare Part D “clawback”—that is, the amount the Medicaid program will no longer pay when the new Medicare prescription drug program begins to pay for prescription medications for individuals who are eligible for both Medicaid and the Medicare benefit.
- Authorizes the Division of Medical Assistance to use up to \$3 million each fiscal year to develop and implement Medicaid cost-containment activities, such as service limits, pre-authorization requirements, requirements that services be provided in the least costly settings, and medical necessity reviews. Before spending any funds to implement a cost-containment strategy, the division must submit a proposal specifying the cost of implementing the strategy and the expected cost savings to the Office of State Budget and Management and must receive its approval.
- Amends G.S. 108A-70.5, the provision that permits the Department of Health and Human Services to recover money spent on Medicaid from recipients' estates. The amended law authorizes DHHS to impose liens against real property, including a recipient's home, to the extent allowed by federal law. Additional new provisions require DHHS to postpone or waive claims against estates when enforcement of the claim would cause an undue hardship on an heir or a beneficiary of the Medicaid recipient (new G.S. 108A-70.6); require DHHS to waive its claim or lien when recovery is not cost-effective (new G.S. 108A-70.7); require DHHS to give Medicaid applicants written notice that receipt of assistance may result in a claim or lien (new G.S. 108A-70.8); authorize DHHS to require county departments of social services to give DHHS information and assistance needed to recover funds; and require DHHS to pay the county 20 percent of the nonfederal share of the recovery (new G.S. 108A-70.9). The new

laws are effective January 1, 2006, and apply to individuals who receive Medicaid on or after that date.

Another law extends the sunset on a 2003 law pertaining to hemophilia drugs. In 2003, the General Assembly enacted G.S. 108A-68.1, which provided that a health care provider does not have to obtain prior authorization from the state Medicaid program before prescribing certain brand-name drugs for hemophilia and blood disorders if no generic drug is available. The section was to expire on July 1, 2006. S.L. 2005-83 (H 916) extends the expiration date to July 1, 2009.

North Carolina Health Choice (Children's Health Insurance Program)

The most significant change to N.C. Health Choice was the transfer of all children under age six to the Medicaid program, as described above. In addition, the 2005 appropriations act provides funding to support increased enrollment in the Health Choice program for children ages six to eighteen. Effective January 1, 2006, the program is authorized to allow up to a 3 percent growth in enrollment every six months. Section 10.22(d) of S.L. 2005-276 adds new subsection (b1) to G.S. 108A-70.2, establishing payment rates for Health Choice providers. By January 1, 2006, Health Choice providers will be reimbursed at rates that are equivalent to 115 percent of Medicaid reimbursement rates. Effective July 1, 2006, Health Choice providers will be reimbursed at the same rates as Medicaid providers.

Senior Prescription Drug Assistance

Section 10.3 of S.L. 2005-276 authorizes the Governor to use up to \$1.5 million during the 2005–06 fiscal year to fully fund the Senior Prescription Drug Access Program, if funds from the Health and Wellness Trust Fund are insufficient to provide services through December 31, 2005. Section 10.4 provides that the program will expire on December 31, 2005, and its members will be eligible for automatic enrollment by DHHS into a federally approved Medicare drug prescription plan, if their incomes are not more than 135 percent of the federal poverty guidelines. However, before automatically enrolling an individual in the program, DHHS must give the individual the opportunity to opt out of automatic enrollment.

Health Information

Controlled Substances Reporting System

The General Assembly created a new system for maintaining information about health care providers who prescribe or dispense controlled substances and about the patients who fill the prescriptions. A special provision in Section 10.36 of the 2005 appropriations act adds Article 5D to G.S. Chapter 90. The new Article requires DHHS to establish and maintain a reporting system of prescriptions for controlled substances listed on Schedules II through V. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services must adopt rules requiring dispensers of controlled substances to report all of the following:

- The federal Drug Enforcement Administration numbers of both the dispenser and the prescriber
- Information about the patient for whom the substance was dispensed, including the patient's name, address, telephone number, and date of birth
- Information about the prescription, including the date it was written, the date it was filled, whether it was a new prescription or a refill, and the prescription number
- Information about the dispensed drug, including the quantity dispensed, the estimated days of supply provided, and the national drug code

Information submitted to DHHS for the reporting system must be kept confidential. It is exempt from the public records act and is not subject to subpoena, discovery, or any other use in civil proceedings. In general, the information may be used only for investigative or evidentiary purposes

related to violations of state or federal laws, but there are additional specified circumstances in which data in the system may be disclosed to other parties. For example, information may be released to persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients. Information that is more than six years old must be purged from the database.

If DHHS finds patterns of prescribing controlled substances that are unusual, it is required to inform the Office of the Attorney General, which will review the findings and determine whether information should be referred to the State Bureau of Investigation for the investigation of possible violations of state or federal controlled substances laws.

The law imposes civil penalties on persons who release, obtain, or attempt to obtain information from the system in violation of the law. It also provides immunity from liability for health care providers that make reports or transmit data to the system, if their actions are in good faith.

Identity Theft Protection Act and Government Agencies' Use of Social Security Numbers

Both private and public health care providers will be affected—though in somewhat different ways—by S.L. 2005-414 (S 1048). Some sections of the law impose requirements on businesses. “Business” is defined in a manner that captures nongovernmental health care providers, but the definition specifically excludes government agencies.⁹ Thus, the requirements applying to businesses will not apply to DHHS or local health departments. However, other sections of the act impose specific requirements on government agencies regarding the use of Social Security numbers (SSNs) and other personal identifying information. Those sections will apply to DHHS and local health departments. This summary addresses the requirements for businesses and the requirements for government agencies separately.

Requirements for businesses. S.L. 2005-414 enacts new Article 2A in G.S. Chapter 75, to be known as the Identity Theft Protection Act. Among other things, the act requires businesses—including health care providers—to protect individuals’ SSNs and other personal information from security breaches.

Effective December 1, 2005, businesses may not intentionally make an individual’s SSN public, or sell, lease, loan, trade, rent, or otherwise disclose an individual’s SSN to a third party without the written consent of the individual, when the business knows or should know that the third party does not have a legitimate purpose for obtaining the SSN. Effective October 1, 2006, businesses may not

- Intentionally put an individual’s SSN on any card required for the individual to obtain the business’s products or services.
- Require an individual to transmit his or her SSN over the Internet, unless the connection is secure or the SSN is encrypted.
- Require an individual to use his or her SSN to access a Web site, unless a password, unique personal identification number, or other authentication device is also required.
- Print an individual’s SSN on information that is mailed to the individual, unless a state or federal law requires the SSN to appear on the document being mailed. If the SSN is required, the document must be mailed in an envelope and must not be visible unless the envelope is opened.

The above prohibitions do not apply in certain circumstances. For example, they do not apply when an SSN is included in an application or other documents related to an enrollment process. They also do not apply if the collection, use, or release of the SSN is for internal verification or administrative purposes.

S.L. 2005-414 requires businesses that own or license personal information to notify individuals when there is a security breach. “Personal information” is defined as a person’s first name (or initial) and last name in combination with certain other identifying information, including SSN, driver’s

9. “Business” is defined as “[a] sole proprietorship, partnership, corporation, association, or other group, however organized and whether or not organized to operate at a profit. . . . Business shall not include any government or governmental subdivision or agency.” G.S. 75-61(1).

license numbers, personal identification numbers, passwords, and biometric data.¹⁰ The definition of personal information explicitly excludes publicly available directories containing information an individual has voluntarily consented to have disseminated or listed and information lawfully available to the general public through government records.

Finally, the law enacts new G.S. 75-64, which requires businesses that maintain or possess records with personal information about North Carolina residents to take reasonable measures to protect against unauthorized access to or use of the information after it is disposed. However, the statute does not apply to health insurers or health care facilities that are subject to and in compliance with the federal HIPAA regulations that protect the privacy and security of medical records.

Requirements for government agencies. Section 4 of S.L. 2005-414 adds a new section to G.S. Chapter 132, North Carolina's public records law, that restricts government agencies' collection and use of Social Security numbers and certain other personal information.¹¹ Beginning December 1, 2005, state and local government agencies may not collect an SSN from an individual unless (1) the agency is specifically authorized by law to collect the SSN or (2) collection of the SSN is imperative for the performance of the agency's legally prescribed duties and responsibilities. An agency that collects SSNs must clearly document that it is authorized to collect SSNs under this standard, and any SSN collected must be relevant to the purpose for which it is collected.

In addition, an agency that is permitted to collect SSNs under this section must segregate the SSN from the rest of the record so that it can be readily redacted in the event of a public records request and, upon request, must provide individuals with a statement of the purpose or purposes for which the SSN is being collected or used. Furthermore, agencies that are permitted to collect SSNs may not use SSNs for any purpose other than the stated purposes, nor may they intentionally communicate or otherwise make public SSNs or other personal identifying information.

All of the above provisions became effective December 1, 2005. Beginning July 1, 2007, government agencies that are permitted to collect SSNs may not

- Intentionally imprint or imbed an SSN on a card that is required to access government services.
- Require an individual to transmit his or her SSN over the Internet, unless the connection is secure or the SSN is encrypted.
- Require an individual to use his or her SSN to access a Web site, unless a password, unique personal identification number, or other authentication device is also required.
- Print an individual's SSN on materials mailed to the individual, unless required to do so by state or federal law. If a law requires the SSN to appear on the mailed materials, the mailing must be in an envelope and must not be visible unless the envelope is opened.

The prohibitions described above do not apply to

- SSNs or other identifying information that is disclosed to government agencies or employees if the disclosure is necessary for the receiving entity to perform its duties. However, the receiving entity must maintain the confidentiality of the SSN.
- SSNs or other identifying information that is disclosed pursuant to a court order, warrant, or subpoena.
- SSNs or other identifying information disclosed for public health purposes, in accordance with the laws in G.S. Chapter 130A.
- Certified copies of vital records.
- Any recorded document in the official records of the register of deeds or any document filed in the official records of a court. However, as of December 1, 2005, persons who prepare

10. This list is not exhaustive. The definition of "personal information" incorporates by reference the definition of "identifying information" that appears in G.S. 14-113.20.

11. Although the new section is part of the public records law, it appears to apply to all of the activities of government agencies, even when the records produced as a result of those activities are exempt from the public records act. Thus, the requirements imposed by the new section apply to local health departments' patient medical records, even though those records are not public records. G.S. 130A-12 provides that local health department records containing privileged medical information or information that is "protected health information" under the HIPAA Medical Privacy Rule are confidential and not public records as defined in G.S. 132-1.

documents for recording or filing by the register of deeds or the courts must not include any person's SSNs or certain other identifying information unless they are expressly required to do so by law or court order, or by the state registrar for a record of a vital event.

Section 5 of S.L. 2005-414 enacts new G.S. 120-61, which requires state government agencies to evaluate their efforts to reduce the dissemination of personal identifying information and make an annual report to the General Assembly. Agencies must give special attention to their collection and use of SSNs. The section further provides that if the collection of an SSN is found to be unwarranted, the state agency must immediately discontinue the collection of SSNs for that purpose. This requirement became effective December 1, 2005.

Autopsy Photos and Recordings

Autopsy reports—including photos, video recordings, and audio recordings—have always been considered public records under North Carolina's public records law. As a result, any member of the public has had the right to inspect and obtain a copy of the photos or recordings. S.L. 2005-393 (H 1543) preserves the public's right to inspect those records, but it carves out an exception to the public records law that limits who may obtain copies of autopsy photos or video or audio recordings. New G.S. 130A-389.1 provides that any person may inspect those records at reasonable times and under the reasonable supervision of the records' custodian. However, the custodian of the records is prohibited from providing copies of the records to persons other than specified public officials, the personal representative of the decedent's estate, or a licensed physician who plans to use the records to confer with attorneys or others on forensic matters. Copies of records with identifying information removed may be provided to medical examiners, coroners, or physicians for the purpose of medical, scientific, or forensic training or research. The law provides for a special procedure before the clerk of court for a person who is denied copies of the records or restricted in the use of them. If the clerk finds good cause to do so, he or she may issue an order authorizing the person to copy or disclose an autopsy photo or recording. In deciding whether there is good cause, the clerk must consider whether the disclosure is necessary for the evaluation of governmental performance, the seriousness of the intrusion into the family's right to privacy, and the availability of similar information through other public records. Unauthorized disclosure of an autopsy photo or audio or video recording is a Class 2 misdemeanor.

Cancer Registry

G.S. 130A-209 requires health care facilities and providers to report diagnoses of cancer to a central cancer registry. S.L. 2005-373 (S 506) amends this law to require facilities and providers to report diagnoses of benign brain or central nervous system tumors as well.

Health Care Power of Attorney

North Carolina's health care power of attorney law has long had an internal inconsistency. G.S. 32A-19(b) provided that a health care agent could be authorized to make decisions for the principal regarding anatomical gifts, autopsies, or disposition of remains. However, G.S. 32A-20(b) provided that the health care power of attorney was revoked upon the death of the principal. Since the power of attorney was revoked, it was unclear whether the authority the health care agent had apparently been granted under G.S. 32A-19(b) should be honored.

S.L. 2005-351 (H 967) clarifies this issue by amending G.S. 32A-20(b) to provide that the health care power of attorney is revoked upon death *except* for purposes of exercising any authority granted to the health care agent to make decisions regarding anatomical gifts, autopsies, or disposition of remains. The act also modifies the statutory health care power of attorney form in G.S. 32A-25 to take this change into account and makes conforming changes to other laws as follows:

- G.S. 130A-398 lists the individuals who may request an autopsy of a decedent. The new law adds to the list a health care agent granted authority by the principal to request an autopsy.
- G.S. 130A-404(b) provides that, if a person has not made an anatomical gift before death in accordance with state law, certain persons may be asked to make the anatomical gift. The persons are listed in priority order and include the decedent's spouse, adult children, and other close relatives. The new law puts at the top of the list a health care agent granted authority by the principal to make an anatomical gift.

The new law became effective October 1, 2005, and applies to health care powers of attorney created on or after that date.

Health Care Professions

Medication Aides

The North Carolina Board of Nursing and DHHS have been working together for several years to develop standards for non-health care providers who administer medications in health care facilities, correctional facilities, and schools. After jointly conducting a pilot project, the board and DHHS recommended legislation to set standards for training, competency, and registration of medication aides. In March 2005, identical bills that would have authorized and regulated the use of unlicensed personnel as medication aides were introduced in the House (H 783) and Senate (S 662). As initially drafted, those bills would have

- explicitly authorized the use of medication aides in health care facilities licensed under G.S. Chapter 131E, Articles 5 (hospitals), 6 (nursing homes, home care agencies, and ambulatory surgical facilities), and 10 (hospice facilities); in adult care homes licensed under G.S. Chapter 131D; in facilities offering mental health, developmental disabilities, and substance abuse services; in schools; and in Department of Correction facilities;
- authorized the North Carolina Board of Nursing to develop standards for medication aide training; and
- established a medication aide registry listing all persons who have successfully completed the medication aide program and passed a state competency exam.

Both bills were referred to the health committees in their respective chambers but were not acted on further. However, the 2005 appropriations act includes a special provision that contains some of the provisions of those bills.

Section 10.40C(b) of S.L. 2005-276 requires the North Carolina Board of Nursing to establish standards for medication aide training. Section 10.40C(c) enacts new G.S. 131E-270, which requires DHHS to establish and maintain a medication aide registry that contains the names of all persons who have successfully completed a training program approved by the Board of Nursing and passed a competency exam. Some health care facilities must not employ or use a person as a medication aide without first verifying that the person is listed on the registry.¹² A separate special provision, section

12. It is not clear which health care facilities are affected. Section 10.40C addresses medication aides in nursing homes, but it is unclear whether and to what extent the section affects medication aides in other health care facilities. The new statute that requires DHHS to establish the medication aide registry and employers to consult it appears in Article 16 of G.S. Chapter 131E, Miscellaneous Provisions. However, the use of medication aides is addressed only in a new section added to Article 6, Part 1, of G.S. Chapter 131E, which governs the licensure of nursing homes. The first sentence of subsection (a) of new G.S. 131E-114.2 states that facilities licensed under Part 1—that is, nursing homes—may use medication aides to perform the technical aspects of medication administration. It does not appear to authorize the use of medication aides in health care facilities licensed under other parts of G.S. Chapter 131E. However, subsection (a)(1) refers to the use of medication aides in facilities licensed under Article 5 (hospitals) and Article 10 (hospice facilities), as well as those licensed under Article 6, Part 1. Those health care facilities, as well as others not named, have long had a practice of using unlicensed personnel as medication aides. See N.C. Board of Nursing, Fact Sheet: Medication Aide Project, available on the Internet at <http://www.ncbon.org/education-factsheet.asp>.

10.40D(f), authorizes local boards of education to adopt policies and procedures permitting unlicensed health care personnel to administer medications in schools. That section—which is described in more detail under “School Health,” above—also refers to the new registry and training requirements set forth in new G.S. Chapter 131E.

Finally, subsection (b) of new G.S. 131E-114.2 requires the Medical Care Commission to adopt rules addressing the training and competency of medication aides, requirements for listing in the medication aide registry, and requirements for the supervision of medication aides by licensed health professionals or qualified supervisory personnel.

Section 10.40D of S.L. 2005-276 directs the Secretary of Health and Human Services and the President of The Community Colleges System to convene a study group to make recommendations to the 2006 session of the General Assembly regarding the training, evaluation, and supervision of medication aides. In addition, DHHS must continue its pilot program on the use of medication aides and report on the program’s status.

Physicians

Most of S.L. 2005-402 (H 1349) makes changes to the Pharmacy Practice Act (see below). However, Sections 5 and 6 increase certain fees payable to the North Carolina Medical Board. The application fee for a license to practice medicine or surgery is increased from \$250 to \$350. The law also increases the fee for a limited license to practice in a medical education and training program (from \$25 to \$100), the annual registration fee for fully licensed physicians (from \$125 to \$175), and the fee for failure to register annually (from \$20 to \$50).

Nurses

S.L. 2005-186 (S 3) authorizes the North Carolina Board of Nursing to adopt rules requiring applicants for license renewal or reinstatement to submit evidence of their continuing competence in the practice of nursing.

Section 9.33 of the 2005 appropriations act amends G.S. 90-171.61, which provides a scholarship loan program for nurses and students who wish to become nurses. Under the amended law, if a loan recipient is unable to attend school for a semester because of limited faculty resources during that semester, the recipient will not be required to forfeit or repay the loan for that semester. This provision can be used for only one semester and extends the recipient’s eligibility for the program by no more than one semester.

Dentists

G.S. 90-30 authorizes the State Board of Dental Examiners to grant a license to practice dentistry in North Carolina to an individual who meets certain educational requirements and passes an examination. In the past, individuals have been required to pass an examination conducted by the board. S.L. 2005-366 (S 711) amends G.S. 90-30 to permit the board to accept the results of other board-approved regional or national clinical examinations that include the performance of procedures on human subjects and that the board determines thoroughly test the applicant’s qualifications.

Errors in references to specific sections of G.S. Chapter 131E contribute to the confusion. G.S. 131E-114.2(b) refers to the medication aide registry “as provided for under G.S. 131E-271,” but section 10.40C(c) established the registry in G.S. 131E-270. Furthermore, Section 10.40D(f), which authorizes school boards to adopt policies permitting the use of unlicensed personnel as medication aides, refers to G.S. 131E-270 as the source of the training requirements that are actually contained in G.S. 131E-114.2 and that appear to apply only to nursing homes. The original medication aide bills, Senate Bill 662 and House Bill 783, would have placed the training requirements in G.S. 131E-270 and established the registry in G.S. 131E-271. Since that is the case, it appears that the General Assembly’s decision to put the training requirements in the nursing home licensure act rather than in the miscellaneous provisions portion of G.S. Chapter 131E was deliberate, but it is not at all clear what that implies for other health care facilities whose use of medication aides is implicitly acknowledged by the reference in G.S. 131E-114.2(a) to health care facilities licensed under other articles.

Pharmacists

S.L. 2005-427 (H 1493) enacts the Pharmacy Quality Assurance Protection Act, Article 4B of G.S. Chapter 90. The stated purpose of the act is to require quality assurance activities to reduce medication errors and to provide for the continuous review of the practice of pharmacy. The new law requires every person or entity holding a valid North Carolina pharmacy permit to establish or participate in a pharmacy quality assurance program to evaluate specified matters, including the causes of medication errors, methods to reduce errors, and the quality of pharmacy practice. The act provides protection for information disclosed in pharmacy quality assurance programs that is similar to the protections provided to medical review committees: the proceedings of such a program and the records and materials it produces are exempted from the North Carolina public records act and are not subject to discovery or introduction as evidence in any civil action, administrative hearing, or Board of Pharmacy investigation against persons or entities permitted or licensed under the Pharmacy Practice Act. However, this protection does not extend to records that are used by the program but available independently from other sources.

The act also provides a means for the Board of Pharmacy to obtain information about medication errors from a pharmacy permit holder. Upon receipt of written notice from the board that it has commenced an investigation against a pharmacist, the permittee must compile and provide documentation of any known medication error made by the pharmacist within the twelve months preceding the investigation, if the error resulted in a death or caused the patient to obtain medical care. However, the documentation may not include the proceedings or records of a pharmacy quality assurance program.

S.L. 2005-402 authorizes the Board of Pharmacy to increase certain fees, including application fees, fees for license renewals and reinstatements, and annual registration fees, among others. An uncodified provision, Section 1, states that the General Assembly's goal is for the board to use the funds generated by the increases to conduct investigations and inspections and directs the board to annually expend at least \$100,000 of the funds generated on a Pharmacy Recovery Network. The law also authorizes the board to increase the number of continuing education hours licensed pharmacists must obtain from ten hours per year to thirty hours every two years, with a minimum of ten each year.

Perfusionists

Perfusionists are health care personnel who operate heart and lung machines during cardiac surgery and other procedures. In the past, unlicensed personnel have been permitted to perform this function. S.L. 2005-267 (S 1059) enacts new G.S. Chapter 90, Article 40, the Perfusionist Licensure Act. The act defines the practice of perfusion and requires perfusionists to be licensed. It creates the North Carolina Perfusion Advisory Committee and authorizes it to determine the qualifications and fitness of applicants for licensure as perfusionists, to issue or deny licenses, to revoke licenses or take other disciplinary actions, to establish continuing education standards for licensees, and to adopt rules necessary to carry out the act. The act establishes a schedule of fees for licenses and renewals, to be paid to the North Carolina Medical Board and used to carry out the purposes of the Perfusionist Licensure Act. Perfusionists must obtain licenses by July 1, 2006, and must practice under the supervision of a physician who is licensed to practice medicine in North Carolina. Section 2 of S.L. 2005-267 is a grandfather clause that directs the Perfusion Advisory Committee to issue a license to any person who has been practicing perfusion in a licensed health care facility in the five years immediately preceding application for a license, or within five of the eight years immediately preceding application, notwithstanding the new requirements. The grandfather clause will expire on December 31, 2007.

Chiropractors

A special provision in the 2005 appropriations act prohibits health insurers from imposing higher co-payments for the services of a chiropractor than they would charge a primary care physician for treatment of the same condition. This change to G.S. 58-50-30, which is found in Section 6.29 of

S.L. 2005-276, clarifies that insurers may not charge specialist co-payments when a chiropractor is providing primary care that would qualify for a lower, nonspecialist co-payment if it were provided by a physician.

Acupuncturists

S.L. 2005-379 (H 1357) amends the acupuncture practice laws. The act amends G.S. 90-455, which sets forth the qualifications for licensure, to allow the Acupuncture Licensing Board to grant a license to an applicant who has been continuously licensed to practice acupuncture in another state for at least ten years, if the following conditions are met: (1) the other state's requirements for licensure meet or exceed North Carolina's, (2) the applicant has met certain continuing education requirements, and (3) there have been no disciplinary actions against the applicant. Additional changes to G.S. 90-455 require applicants to be of good moral character, to not be currently engaged in practice or conduct that would constitute grounds for discipline by the board, and to submit a signed form attesting to the applicant's intention to adhere to the ethical standards adopted by the board. The law also allows acupuncturists who are not presently practicing to apply for inactive licensure status and sets forth the requirements for licensure for applicants whose licenses have been suspended or have expired or lapsed. Finally, the law authorizes the board to set and enforce continuing education standards for licensed acupuncturists and to establish and collect certain fees.

Recreational Therapists and Occupational Therapists

S.L. 2005-378 (H 613) rewrites G.S. Chapter 90C, the licensure act for recreational therapists. It changes the title of the chapter from Therapeutic Recreation Personnel Certification Act to North Carolina Recreational Therapy Licensure Act and makes conforming terminology changes throughout (for example, by changing the name of the State Board of Therapeutic Recreation Certification to the North Carolina Board of Recreational Therapy Licensure). The act modifies the examination, education, and experience requirements for recreational therapists, effective January 1, 2006. Grandfather provisions allow currently certified recreational therapists to be exempt from the new requirements if they submit an application for licensure to the board by January 15, 2008.

S.L. 2005-432 (S 208) amends the Occupational Therapy Practice Act. The act deletes G.S. 90-270.71, which contained detailed requirements for the examination of occupational therapists by the North Carolina Board of Occupational Therapy and replaces the statute with an amendment to G.S. 90-270.70 requiring applicants for licensure to pass an examination approved by the board. Another amendment to G.S. 90-270.70 requires applicants for licensure who were trained outside the United States to meet examination eligibility requirements established by a credentialing agency recognized by the board. The new law also provides for issuance of 120-day limited permits to individuals who have met all requirements for examination but who have not yet taken or received the results of the examination. It alters the grounds for disciplinary actions by the board under G.S. 90-270.76 to include engaging in unprofessional conduct, having disciplinary action taken by a licensure authority in North Carolina or another state, and being unfit or incompetent. The act enacts new G.S. 90-270.80A, authorizing the board to assess civil penalties and charge costs of disciplinary actions against individuals found to be in violation of licensure laws or rules. An amendment to G.S. 90-270.81 provides that an occupational therapist who irregularly provides consultation to North Carolina occupational therapists or the educational facilities that train them need not be licensed in North Carolina. Finally, S.L. 2005-432 alters the membership of the board; provides for removal of members for neglect of duty, incompetence, or unprofessional conduct; and authorizes the board to communicate any disciplinary actions it takes to relevant state and federal authorities and other states' occupational therapist licensing boards.

Miscellaneous

Physicians, hospitals, dentists, and podiatrists who charge their patients more for anatomic pathology services than the providers themselves are billed will have to disclose those mark-ups under

new G.S. 90-681, enacted by S.L. 2005-415 (H 636). The disclosure must be made in writing and include, among other things, the amount charged to the health care provider by the laboratory. The law provides exceptions for licensed practitioners performing or supervising anatomic pathology services and for hospitals or physician group practices that have a physician employee or physician under contract to perform or supervise the services. Failure to make a required disclosure is a Class 3 misdemeanor.

Section 2 of S.L. 2005-415 amends G.S. 90-18(a), the statute that prohibits the practice of medicine without a license. The statute provides that a person who practices medicine or surgery without a license is guilty of a Class 1 misdemeanor. The amendment increases the penalty to a Class I felony if the person practicing without a license is an out-of-state practitioner.

S.L. 2005-431 (S 705), which amends G.S. Chapter 90, Article 5C, the substance abuse professionals certification law, is summarized in Chapter 16, "Mental Health."

Health Care Facilities

Certificate of Need

North Carolina's certificate of need (CON) law was enacted in 1977 with the goal of controlling health care costs by reducing unnecessary duplication of health care services and facilities. The law requires health care providers to obtain a CON from DHHS before offering certain new services or constructing or acquiring certain facilities or equipment. Facilities that require a CON include hospitals, nursing homes, adult care homes, home health agencies, and ambulatory surgical facilities. In addition, a health care provider must obtain a CON before establishing a new facility, undertaking a capital expenditure of more than \$2 million, changing facility bed capacity or relocating facility beds, or offering certain services, including bone marrow transplantation, neonatal intensive care, and burn intensive care services. A CON is also required to acquire certain equipment, including air ambulances, magnetic resonance imaging (MRI) scanners, and positron emission tomography (PET) scanners.¹³

S.L. 2005-325 (S 740) adds the following to the list of facilities, services, activities, and equipment for which a CON is required:

- Most cardiac catheterization services
- Long-term care hospitals
- The opening of an additional office by a hospice
- Kidney disease treatment centers
- Linear accelerators (machines used to produce radiation for cancer treatment)
- Simulators (machines that produce diagnostic radiographs)

Separate legislation addresses the regulation of gastrointestinal endoscopy rooms under the CON law. A gastrointestinal endoscopy room is a room used to perform procedures for visualizing the gastrointestinal lining and adjacent organs for diagnostic or treatment purposes. Prior CON law did not distinguish between general surgical operating rooms and gastrointestinal endoscopy rooms. S.L. 2005-346 (H 1060) defines and distinguishes between the two types of rooms, adds gastrointestinal endoscopy rooms to the list of facilities for which a CON is required, and adds to the list of activities for which a CON is required a change in designation of an operating room to a gastrointestinal endoscopy room (or vice versa). Section 7 of S.L. 2005-346 provides a procedure by which existing facilities can be exempted from the new requirements.

13. These lists are not exhaustive. The complete list can be gleaned from the definitions section of the CON law, G.S. 131E-177.

Home Care Clients' Bill of Rights

A special provision in the 2005 appropriations act enacts the Home Care Clients' Bill of Rights. Section 10.40A(n) of S.L. 2005-276 adds new Part 3A to G.S. Chapter 131E, Article 6. The new law includes a declaration of home care clients' rights, including (but not limited to) the following:

- The right to be informed and participate in the client's plan of care
- The right to voice grievances about care
- The right to have personal and medical records kept confidential and not disclosed without appropriate written consent¹⁴
- The right to be free of mental and physical abuse, neglect, and exploitation
- The right to accept or refuse services
- The right to be informed of adverse actions against the home care agency's license

The Department of Health and Human Services is responsible for enforcing the new provisions and must investigate complaints within specified time limits, depending on the allegation. For example, a complaint of neglect must be investigated within forty-eight hours, while a complaint alleging a life-threatening situation must be investigated immediately. Home care agencies must provide each client with a copy of the declaration of rights and certain other information, including the address and telephone number of the DHHS section responsible for enforcing the new provisions.

Public Hospitals

S.L. 2005-70 (H 869) amends the conflict of interest law for public hospitals. G.S. 131E-14.2 prohibits public hospital employees and members of public hospital boards of directors from acquiring any interest in

- a hospital facility or property that is included or planned to be included in a hospital facility, or
- a contract or proposed contract for materials or services to be furnished or used in connection with a hospital facility (with the exception of employment contracts for employees).

S.L. 2005-70 makes two changes to G.S. 131E-14.2. First, the statute formerly specified that "direct or indirect" interests in contracts were prohibited. The word "indirect" has been deleted; thus, only direct interests in contracts are prohibited. Second, the new law provides that the prohibitions listed above will not apply if the director or employee is not involved in making or administering the contract.

Section 14 of S.L. 2005-238 (H 1117) amends G.S. 131A-6 to authorize public agencies, including public hospital authorities, to grant mortgages or security interests in their health care facilities in order to finance hospital facilities and equipment.

Another new law addresses public hospital investments. S.L. 2005-417 (S 443) authorizes public hospitals to deposit with the State Treasurer any funds not required for immediate disbursement, as well as funds held in reserves or sinking funds. The State Treasurer may invest the funds as provided in G.S. 147-69.2.

Section 4 of S.L. 2005-417 enacts a new statute to regulate funds received and held by UNC Hospitals. G.S. 116-37.2 provides that the Board of Directors of the UNC Health Care System is responsible for the custody and management of those funds and requires the board to adopt policies and procedures for the administration of the funds. The new law requires UNC Hospitals funds to be deposited with the State Treasurer, who will hold them in trust. The funds and their investment earnings will be available for expenditure by UNC Hospitals without further authorization by the General Assembly.

A special provision in the 2005 appropriations act directs DHHS to allocate \$3 million of the funds it receives for the 2005–06 fiscal year to rural hospitals in need of assistance in paying operating

14. The impact of this provision on general medical confidentiality law is unclear. However, it seems unlikely that the General Assembly intended the declaration of rights to alter existing laws that permit or require disclosure of confidential patient information without consent when necessary for the home care provider to comply with other legal duties—such as the duty to make appropriate reports to adult protective services or the duty established in this same new law to make medical records available to DHHS during an investigation of an alleged violation.

expenses. The department must establish criteria for distribution of the funds, including the number of indigent patients served by the hospital, the number of Medicaid recipients served, the per capita income of the area served by the hospital, and the hospital's financial needs.

Miscellaneous

Several other new laws affecting health care facilities are summarized in Chapter 22, "Senior Citizens." S.L. 2005-66 (S 572) creates a licensure category for assisted living communities that serve only elderly adults. S.L. 2005-4 (S 41) provides for criminal history checks for employees of long-term care facilities. Several sections of the 2005 appropriations act impose new requirements on home care agencies and adult care homes for the aged and disabled.

Other Laws of Interest

Immunity from Liability for Volunteer Emergency Responders

S.L. 2005-273 (H 1297) amends G.S. 1-539.10 to provide qualified immunity from liability for Medical Reserve Corps members, members of Community Emergency Response Teams, and other volunteers engaged in providing emergency services. The law also defines "emergency services" in G.S. 1-539.11 as "the preparation or carrying out of functions to prevent, minimize, and repair injury and damage resulting from natural or man-made disasters," including medical, health, and rescue services (among others).

Methamphetamine Lab Prevention Act

S.L. 2005-434 (H 248) restricts the sale of pseudoephedrine, a popular over-the-counter decongestant that can be used to manufacture methamphetamine. The restrictions include the following:

- Pseudoephedrine products in tablet or caplet form must be stored and sold from behind a pharmacy counter.
- Nonprescription pseudoephedrine products may be sold only to individuals age eighteen and older. Retailers must require purchasers to furnish photo identification showing date of birth.
- Retailers must keep a record of disposition of pseudoephedrine products that records the name and address of each purchaser, identifies each product purchased, and specifies the amount of grams purchased and the purchase date. Each purchaser must sign the record at the time of purchase. The retailer must maintain records for two years and make them available for inspection by authorized law enforcement officials.
- Individuals are prohibited from purchasing or attempting to purchase over-the-counter more than two packages containing a total of six grams of pseudoephedrine in a single purchase and from purchasing or attempting to purchase over-the-counter more than three packages containing a total of nine grams in a thirty-day period.

The restrictions do not apply to pseudoephedrine products in the form of liquid, liquid capsule, or gel capsule; nor do they apply to pediatric products labeled and intended for administration to children under age twelve.

The law also requires retailers who sell pseudoephedrine products covered by the restrictions to post signs about the restrictions and to require their employees to participate in a training program. There are criminal penalties for retailers, employees, and purchasers who willfully and knowingly violate the restrictions.

State Veterinarian's Authority to Control Contagious Animal Diseases

In 2001, in response to an epidemic of foot and mouth disease among animals in Europe, the General Assembly enacted legislation strengthening the authority of the State Veterinarian to respond to contagious animal diseases with the potential for serious and rapid spread. Among other things, S.L. 2001-12 authorized the State Veterinarian to stop and inspect vehicles transporting animals, to quarantine areas to prevent the spread of contagious animal diseases, and to order that infected animals be destroyed. The original law had a sunset date of April 1, 2003. In 2003 the General Assembly extended the sunset to October 1, 2005.¹⁵ S.L. 2005-21 (S 210) extends the sunset again, to October 1, 2009.

Medical Examiner Fees

G.S. 130A-387 requires the state or a county to pay a fee for postmortem investigations conducted by medical examiners. S.L. 2005-368 (S 505) increases the fee from \$75 to \$100 per investigation.

Interpreters/Translitterators

G.S. Chapter 90D, the Interpreter and Translitterator Licensure Act, governs the provision of interpretation or transliteration services to individuals who are deaf, hard of hearing, or otherwise dependent on manual modes of communication. G.S. 90D-8 allows the North Carolina Interpreter and Translitterator Licensing Board to grant provisional licenses to individuals who meet specified criteria. S.L. 2005-299 (H 1507) extends eligibility for provisional licensure to individuals who do not meet the certification or education requirements established under prior law but have completed specified training requirements. The act enacts G.S. 90D-14 to authorize the board to assess civil penalties for violations of the statutes or the board's rules.

Volunteer Rescue/Emergency Medical Services Fund

The North Carolina Department of Insurance maintains the Volunteer Rescue/Emergency Medical Services (EMS) Fund to provide grants to volunteer rescue and EMS units for the purchase of equipment and for capital improvements. The Department of Health and Human Services provides the Department of Insurance a priority list for EMS equipment funding. S.L. 2005-283 (S 687) directs the North Carolina Association for Rescue and Emergency Medical Services, Inc., to provide DHHS with an advisory priority list for rescue equipment funding. It also provides that grants may no longer be used to pay highway use taxes on equipment purchases.

Nutrition in Universities and Community Colleges

Section 9.28 of the 2005 appropriations act directs the UNC Board of Governors and the State Board of Community Colleges to adopt policies for any food programs they operate to prohibit the use of cooking oils containing trans-fatty acids and the sale of processed foods containing trans-fatty acids. The policies must apply to contracts entered or renewed on or after August 1, 2006.

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15. S.L. 2003-6.