



## INTRODUCTION

We find ourselves in a sort of legislative limbo with session still officially underway but very few committees meeting and just a handful of bills being finished up here or there. The Senate has been absent a great deal and the House has been stripping bills or putting several bills together to send to the Senate where their fate remains less than certain. It is a difficult position for groups wanting to get things done at the legislature as they refuse to move most bills pending while tinkering at the edges on bills that the House and Senate want to resolve. Seems they are all waiting on a budget resolution that is not happening.

Speaking of the budget, the stalemate continues now for over seven weeks with very little if any discussion apparent between the Legislative Leadership and the Governor's Office. Not sure how they can resolve their differences if they won't even get in a room together and discuss them? Reminds me of an old MASH episode where the peace talks broke down over the type of table that the parties wanted to use in negotiations.

Both the House and Senate appear to be back this week to take care of business, and we are hopeful of an indication of how this session will be wrapped up. As soon as we know more than just rumor (or at least a very good one!), we will let you know.



## NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS



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### FOR MORE INFORMATION:

Colleen Kochanek  
Ashley Matlock Perkinson  
Rachel E. Beaulieu  
P.O. Box 1038  
Wake Forest, NC 27588  
919.747.9988

[colleen@kochaneklawgroup.com](mailto:colleen@kochaneklawgroup.com)  
[ashley@perkinsonlawfirm.com](mailto:ashley@perkinsonlawfirm.com)  
[rachel@beaulieuedlaw.com](mailto:rachel@beaulieuedlaw.com)  
[www.kochaneklawgroup.com](http://www.kochaneklawgroup.com)

## BILL UPDATES

**SENATE BILL 86, Small Business Health Care Act, which would establish standards for association health plans and Multiple Employer Welfare Arrangements, was approved by the House and the Senate and has been sent to the Governor for his signature.**

**SENATE BILL 320, Regional Water Systems and State Grants. This legislation was vetoed by the Governor on August 2<sup>nd</sup>. In his veto, Governor Cooper provides that, “Local governments have an important duty to resolve differences between themselves and ensure fair access to vital resources like water for their residents. However, they should not use state law to seek an unfair advantage in negotiations.” **The Senate has not yet scheduled a time to hold a vote to over-ride the Governor's veto.****

**SENATE BILL 361, Healthy NC, was approved by the Senate at the end of April, but it has grown on the House side to include a number of health-related issues. The House Health Committee heard the bill at the end of July and added a number of provisions, including several that expand telehealth access. The House version of the bill would:**

- implement the Psychology Interjurisdictional Licensure Compact, which seeks to increase public access to professional psychological services by allowing telepsychological practice across state lines and temporary in-person, face-to-face services into a state in which the psychologist is not licensed to practice;
- establishes rules for the operation of the Compact;
- expand the providers eligible to perform the first commitment examinations for involuntary commitment of individuals with mental illness or substance use disorders required by law to include licensed marriage and family therapist, except when the individual to be examined is married to a patient of the therapist;
- if the annual or biennial inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation must not cite, as part of the annual inspection, any non-compliance with any law or regulation that was cited during a physical plant and life-safety inspection, unless:
  - the non-compliance with the law or regulation continues and the non-compliance constitutes a Type A1, Type A2 or Type B violation, as specified in state law;
  - the facility has not submitted a plan of correction for the physical plant or life-safety citation that has been accepted by the section at DHSR that conducted the initial inspection; or
  - the non-compliance with the physical plant or life-safety law and regulation cited by the section has not been corrected within the time frame allowed for correction or has increased in severity;
- designate the month of May as Lupus Awareness Month and create the Lupus Advisory Council
- change the statute regarding step therapy protocols by:
  - expanding the application of the statute to an insurer that maintains one or more closed formularies for or restricts access to covered prescription drugs or devices and an insurer that requires an enrollee in a plan with an open or closed formulary to use a prescription drug or sequence of prescription drugs, other than the drug the enrollee's health care provider recommends, before the insurer provides coverage for the recommended prescription drug;
  - removing the requirement that participating physicians participate in the committee approving step therapy protocols;

- requiring the insurer to update protocols based on a review of new evidence, research, and newly developed treatments;
- deleting the requirement of providing coverage for a restricted access drug or device to an enrollee without requiring prior approval or use of a nonrestricted formulary drug if an enrollee's physician certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the enrollee's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the enrollee's health or ineffective in treating the condition again; and
- modifying the requirements for an exception process to require that an enrollee or the enrollee's prescribing provider be allowed to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device or the drug requested by the prescribing provider, if it is determined to be medically necessary and appropriate by the enrollee's prescribing provider and the prescription drug is covered under the current health benefit plan. The exception request is required to be granted if the prescribing providers submitted justification and clinical documentation demonstrate five specified qualifications;
- set regulations for health benefit plans sold on the individual market that provide coverage for prescribed, orally administered anticancer drugs that are used to kill or slow the growth of cancerous cells and that provides coverage for intravenously administered or injected anticancer drugs, including prohibiting plans from imposing a copayment, coinsurance percentage, or deductive or any combination thereof to the insured for oral originator oncology products that are greater than that charged to the insured for intravenously administered or injected anticancer drugs;
- make changes to Medicaid and NC Health Choice Clinical Coverage Policy No. 1H, Telemedicine and Telepsychiatry:
  - All behavioral health providers who are directly enrolled as providers in the Medicaid and NC Health Choice programs, including licensed professional counselors, licensed marriage and family therapists, certified clinical supervisors, and licensed clinical addictions specialists, would be included in the coverage policy as providers who may bill Medicaid or NC Health Choice for telemedicine and telepsychiatry services and as providers who may bill for a facility fee.
  - DHHS would reimburse for telemedicine and telepsychiatry services performed in a recipient's home or delivered from a licensed practitioner's home.
  - A referral would not be required for the use of telemedicine or telepsychiatry services above and beyond what is required for face-to-face services.
  - The delivery of telemedicine or telepsychiatry over the phone or by video cell phone would be covered.
  - A referring provider who is eligible to bill for facility fees and a receiving provider who is eligible to bill for facility fees would be allowed to bill for facility fees related to the provision of telemedicine or telepsychiatry on the same date of service.
  - Telemedicine and telepsychiatry services would not be subject to the exact same restrictions as face-to-face contacts in office-based settings. The clinical coverage policy would be updated to reflect best practices for telemental health and to maintain the expectation for the same standard of care.

- increase access to telehealth services through Medicaid and NC Health Choice:
  - The term "telehealth" would be used instead of "telemedicine" in all clinical coverage policies. For the purposes of Medicaid and NC Health Choice coverage, telehealth would be defined as the delivery of health care-related services through real-time interactive audio and video technology, store and forward services that are provided by asynchronous technologies as the standard practice of care where medical information is sent to a provider for evaluation, or an asynchronous communication in which the provider has access to the recipient's medical history prior to the telehealth encounter.
  - DHHS would be required to promote access to health care for Medicaid and NC Health Choice recipients through telehealth services.
  - DHHS would require all Medicaid providers providing telehealth services to be licensed in North Carolina to provide the service rendered through telehealth.
  - DHHS would require health care facilities that receive reimbursement for telehealth consultations and have a Medicaid provider who practices in that facility establish quality-of-care protocols and patient confidentiality guidelines to ensure all requirements and patient care standards are met as required by law.
  - DHHS could not require: a provider to be physically present with a patient, the use of telehealth if an in-person provider is reasonably close by, additional approval for telehealth services, or a provider to be a part of a telehealth network or particular agency to provide telehealth services. Telehealth services could not be denied based solely on the technology used.
  - Medicaid and NC Health Choice coverage and reimbursement for telehealth services would be equivalent to the reimbursement and coverage for the same services if provided in person and any deductible, copayment, or coinsurance requirement is equivalent to the same service if it was provided to the patient in person.
- ensure telehealth services are also covered through private benefit plans and the State Health Plan:
  - A health benefit plan would be prohibited from excluding a covered health care service or procedure solely because it is delivered through as a telehealth.
  - A health benefit plan could require a deductible, a copayment, or coinsurance for a telehealth service but the amount could not exceed that charged for an in-person consultation.
  - Apply the same telehealth coverage required of private benefit plans to the State Health Plan.
- create the 17-member North Carolina Healthcare Solutions Task Force to examine innovative solutions to health care access issues, including members appointed by the House and Senate, AHEC, the Sheps Center for Health Services Research, the N.C. Institute of Medicine, the Office of Rural Health at DHHS;
- direct the Task Force to address its work in two stages, the first to identify metrics to provide an accurate assessment and measurement of the state of access to health care in North Carolina, and the second to identify any issues relating to access to health care in North Carolina and to develop innovative solutions that will increase access to health care and improve the state of access to health care in North Carolina as measured by the identified metrics;
- direct that Stage One begin no later than October 1, 2019, establish areas for examination and specify that the Task Force report to the Joint Legislative Oversight Committee on Health and Human Services at the conclusion of Stage One, no later than April 1, 2021;

- establish activities for Stage Two and require reports to the Joint Legislative Oversight Committee on Health and Human Services beginning no later than April 1, 2022 and annual until April 17, 2030; and
- terminate the Task Force on the data it submits its final report in 2030.

**The bill as amended was approved by the House Health Care Committee and the Full House and will next be considered by the Senate.**

SENATE BILL 432, Birth Center & Pharm Benefits Mgr. Licensure, was heard in the House Health Committee where the previous provisions were deleted and a new version was approved. The new version would:

**Enact the Birth Center Licensure Act, which:**

- defines birth center as a facility licensed for the primary purpose of performing normal, uncomplicated deliveries that is not a hospital or ambulatory surgical facility, and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy;
- requires DHHS to review and, as necessary, revise the Freestanding Birth Center Fee Schedule every three years to ensure that the fees are sufficient to cover the costs of services and that the cost for any State-mandated newborn screening is reimbursed at least at cost;
- directs DHHS to inspect birth centers to investigate unexpected occurrences involving death or serious physical injury and reportable adverse outcomes;
- requires all licensed birth centers be subject to DHHS inspections at all times;
- provides access to licensed premises by authorized DHHS representatives and, effective December 1, 2019, makes it unlawful for any person to resist proper entry by authorized DHHS representatives upon premises other than a private dwelling;
- grants DHHS the authority to investigate birth centers in the same manner as it investigates hospitals under GS 131E-80(d);
- permits public disclosure of information received by the Commission or DHHS through filed reports, license applications, or inspections except where disclosure would violate laws concerning patient records and confidentiality;
- creates the seven-member NC Birth Center Commission of DHHS to establish standards for licensure, operation, and regulation of birth centers in the state;
  - provides that three members of the Commission will be representatives of the N.C. Obstetrical and Gynecological Society, three members will be representatives of the North Carolina Affiliate of the American College of Nurse-Midwives and one member will be a public member appointed by the Governor;
  - requires the Commission to adopt rules establishing seven licensure requirements, including: (1) a requirement that the birth center obtain and maintain accreditation with the Commission for the Accreditation of Birth Centers (CABC), as well as documentation and reporting requirements; (2) a requirement that the birth center establish procedures specifying the criteria by which each person's risk status will be evaluated at admission and during labor, pursuant to CABC standards; and (3) a requirement that the birth center develop and submit a plan for complying with the standards of CABC with respect to transfer of care procedures;
  - requires DHHS to enforce the licensure provisions and any rules adopted by the Commission;
  - allows the Commission, its members, and staff to release confidential or nonpublic information to any health care licensure board or authorized DHHS personnel with enforcement or investigative responsibilities concerning licensure action;

- adds provisions requiring licensure for the operation of a birth center in the state, which are applicable one year after the adoption of rules by the Commission;
  - provides that a birth center license is valid for one year and is required to designate the number of beds and the number of rooms on the licensed premises;
  - establishes a \$400 nonrefundable annual license fee to be credited to DHHS as a departmental receipt and applied to offset costs for licensing and inspecting birth centers, as well as a nonrefundable \$17.50 annual per-birthing room fee;
  - requires birth centers to post the license on the licensed premises in an area accessible to the public;
  - allows currently operating and accredited birthing centers to continue operations as the Commission is constituted and promulgates permanent rules;
- authorizes the denial, suspension, or revocation of a license for substantial failure to comply with the procedures set out in the legislation or rules adopted by the Commission;
- authorizes the DHHS Secretary or a designee to suspend the admission of any new patients to a birth center if the birth center conditions are detrimental to the health or safety of any patient;
- prohibits a licensed birth center from representing or providing services outside of the scope of the license and establishes limits on services:
  - surgical procedures must be limited to those normally accomplished during an uncomplicated birth,
  - no abortions can be performed,
  - no general or conduction anesthesia can be performed, and
  - no vaginal birth after cesarean or trial of labor after cesarean can be performed; and
- makes it a Class 3 misdemeanor to operate a birth center without a license, punishable by a fine of up to \$50 for the first offense and up to \$500 for each subsequent offense.

**Establish standards for pharmacy benefit managers, which:**

- set out definitions including defining pharmacy benefits manager to include any entity who contracts with a pharmacy on behalf of an insurer or third-party administrator to administer or manage prescription drug benefits to (1) process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists, (2) pay pharmacies or pharmacists for prescription drugs or medical supplies, or (3) negotiate rebates with manufacturers for drugs.
- require licensure by the Commissioner of Insurance for a person or organization to establish or operate as a pharmacy benefits manager in the state for health benefit plans:
  - direct the Commissioner to prescribe the application for a license;
  - authorize the Commissioner to charge an initial application fee of \$2,000 and an annual renewal fee of \$1,500;
  - set forth five exclusive components the application must contain;
  - require the application to include a signed statement indicating that no officer with management or control of the pharmacy benefits manager has been convicted of a felony or has violated any requirements of applicable state or federal law, or a signed statement describing any relevant conviction or violation;
- restrict a pharmacy benefit manager from prohibiting a pharmacist or pharmacy from charging a minimal shipping and handling fee;
- require that, when calculating the insured's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the health benefit plan, the insurer must include any amounts paid by the insured or paid on the insured's behalf to the extent allowed by state and federal law;

- eliminate the requirement for the Department to report any violations of the statute to the Attorney General;
- require there be a justification for each adjustment or fee for processing a claim or otherwise related to adjudication of a claim, but maintains the provision excluding claims under an employee benefit plan under the Employee Retirement Income Security Act or Medicare Part D;
- clarify the legislation does not abridge the right of a pharmacist to refuse service if the pharmacist believes it would be harmful to the patient, not in the patient's best interest, or if there is a question to the prescription's validity;
- specify that the provisions do not limit overpayment recovery efforts by a pharmacy benefits manager;
- provide that a pharmacy or pharmacist cannot be prohibited or restricted by a pharmacy benefits manager from dispensing any prescription drug consistent with pharmacy licensure laws, including specialty drugs dispensed by a credentialed and accredited pharmacy;
- prohibit a pharmacy benefits manager from penalizing or retaliating against a pharmacist or pharmacy for exercising rights provided unless conduct amounts to a breach of contract;
- establish that a claim for pharmacist services cannot be retroactively denied or reduced after adjudication of the claim unless one of five circumstances apply, including that the original claim was submitted fraudulently;
- require pharmacy benefits managers to ensure that dispensing fees are not included in the calculation of maximum allowable cost price for prescription drugs;
- require pharmacy benefits managers to establish an administrative appeals procedure for reimbursement if less than the net amount that the network paid to the suppliers of the drug;
- authorize pharmacy benefits managers to maintain more than one network for different pharmacy services and allow each individual network to have terms and conditions and require different pharmacy accreditation standards or certification requirements for participating in the network;
- prohibit denying the right to any properly licensed pharmacist or pharmacy from participating in the network on the same terms and conditions of other participants in the network;
- establish that termination of a pharmacy or pharmacist from a network does not release the pharmacy benefits manager from the obligation to make any payment due to the pharmacy or pharmacist for pharmacist services properly rendered according to the contract, excluding cases of fraud, waste, and abuse;
- prohibit a pharmacy benefits manager from, in any way prohibited by HIPAA, transferring or sharing records related to prescription information containing patient-identifiable and prescriber-identifiable data to a pharmacy benefits manager affiliate;
- provide for the enforcement of standards for pharmacy benefit managers by the Commissioner of Insurance and make violations subject to penalties under GS 58-56A-40;
- require the Commissioner of Insurance to report in detail to the Attorney General any violations of laws relative to pharmacy benefits managers; and
- apply to any contracts entered into on or after March 1, 2020.

**The bill as amended was approved by the House Health Committee and will next be considered by the House Finance Committee.**

SENATE BILL 553, Regulatory Reform Act of 2019, was amended in the Conference Committee which resolves the differences between the House and Senate versions by making various changes, including removing the provisions regarding electric standup scooters. **The bill as amended in the Conference Committee is scheduled to be heard by the full Senate on August 20<sup>th</sup>.**

## LEGISLATION ENACTED

HOUSE BILL 106, Inmate Health Care & 340B Program. This legislation would:

- direct the Department of Public Safety, in order to contain medical costs for inmates as required by statute, to: (1) develop a plan to increase the use of the Central Prison Healthcare Complex (CPHC); and (2) by December 1, 2019, submit the plan to the Joint Legislative Oversight Committee on Justice and Public Safety and submit its progress made in achieving cost savings under the plan, the amount of any actual and estimated cost savings, and any obstacles to increasing the usage of the health services facilities at CPHC and the North Carolina Correctional Institution for Women;
- require the Department of Public Safety to report quarterly to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the reimbursement rate for contracted providers and to **randomly audit high-volume contracted providers to ensure adherence to billing at the contracted rate**;
- direct the Department of Public Safety, Health Services Section, to report to the Joint Legislative Oversight Committee on Justice and Public Safety and to the chairs of the House and Senate Appropriations Committees on Justice and Public Safety by February 1, 2020, on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates;
- direct the Department of Public Safety and the Department of Health and Human Services to work together to enable social workers in the Department of Public Safety, Health Services Section, to qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates;
- require the Department of Public Safety, Health Services Section, by August 1, 2019, to report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the **feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care**;
- **direct the Department of Public Safety, Health Services Section, to establish a telemedicine pilot program to provide physical health services to inmates in remote correctional facilities**;
- require the pilot program to be established with consideration of the results of the study referenced above with the goal of the pilot program to assess whether the use of telemedicine decreases costs for inmate transportation, custody, and outside providers while improving access to care;
- provide that, while designing the telemedicine pilot program, the Department of Public Safety, Health Services Section, must consult UNC Health Care; the 2012 University of North Carolina, Kenan-Flagler Business School report on telemedicine; and Finding 6, Report Number 2018-08, from the Joint Legislative Program Evaluation Oversight Committee;
- require the telemedicine pilot program to initially be established in two correctional facilities serving male inmates, and be designed to connect the two correctional facility



- pilot sites with the Central Prison Healthcare Complex and its contracted providers' facilities and to be operational on or before January 1, 2020;
- provide that the ability to assess, measure, and evaluate the telemedicine pilot program is integral to the pilot program design. Assessment of the pilot program shall include, but is not limited to, the following measures for each correctional facility pilot site:
    - number and cost of telemedicine encounters by service area;
    - comparison of the number and cost of telemedicine encounters, by service area, to: (1) the number of in-person encounters provided the previous year to inmates housed at that facility; and (2) the number of in-person encounters provided during the pilot period at similar correctional facilities not participating in the pilot;
    - comparison of the number of days lapsed between referral date and treatment date, by service area, to: (1) the number of days lapsed the previous year in that facility; and (2) the number of days lapsed during the pilot period at similar correctional facilities not participating in the pilot;
    - amount of inmate transportation and custody costs avoided from receiving telemedicine;
    - amount of provider transportation costs avoided from providing telemedicine;
    - cost of initial telemedicine equipment and other related costs with descriptions; and
    - obstacles and concerns related to expanding telemedicine to other correctional facilities.
  - require the Department of Public Safety, Health Services Section, on or before January 1, 2021, to report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services on the assessment criteria, including any additional findings, and to make recommendations on whether to expand the telemedicine pilot program to additional sites, including accompanying costs and anticipated savings, and recommendations on which correctional facilities would be most advantageous to include in the pilot due to lack of access or costs associated with transportation and custody; and
  - require the Department of Public Safety (DPS) to establish and implement a partnership with the Department of Health and Human Services (DHHS) in order for DPS to be eligible to operate as a 340B covered entity (a federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices).

**Effective: July 19, 2019, except as otherwise provided.**

HOUSE BILL 228, Modernize Laws Pertaining to NC Medical Board. This legislation modernizes the laws governing the North Carolina Medical Board (Board) and the practice of medicine by:

- defining “licensee” and “inactive license”;
- requiring every licensee to report in writing to the Board within 30 days any incidents that licensee reasonably believes to have occurred involving any of the following: (1) sexual misconduct of any person licensed by the Board under this Article with a patient (patient consent or initiation of acts or contact by a patient would not constitute affirmative defenses to sexual misconduct); (2) fraudulent prescribing, drug diversion, or theft of any controlled substances by another person licensed by the Board. Any person who reports under this section in good faith and without fraud or malice is immune from civil liability. Reports made in bad faith, fraudulently, or maliciously will constitute unprofessional conduct and is grounds for discipline;
- allowing the Board to collect the fee for conducting a background check from the applicant and remit it to the Department of Public Safety;
- requiring 130 weeks of medical education for a physician license;

- amending the requirements for licensure for graduates of international medical schools;
- increasing civil penalties for practice outside the scope of various limited purpose licenses;
- removing geographic limits on where the Board can meet (currently, Raleigh) and allowing the Superior Court in the county where the Board is located to hear appeals of decisions not to issue a license and appeals of disciplinary action (currently, Wake County Superior Court);
- clarifying that the Board retains jurisdiction over an inactive license, regardless of how it became inactive, including a request for inactivation, surrender of a license, or by operation of an order entered by the Board. The Board's jurisdiction over the licensee extends for all matters, known and unknown to the Board, at the time of the inactivation or surrender of the license;
- requiring the program director of every graduate medical education program to report to the Board the following actions involving a physician participating in a graduate medical education training program within 30 days of the date that the action takes effect: (1) any revocation or termination, including, but not limited to, any nonrenewal or dismissal of a physician from a graduate medical education training program; and (2) a resignation from, or completion of, a graduate medical education program or a transfer to another graduate medical education training program;
- amending the requirements for obtaining a medical school faculty license to practice medicine and surgery and providing for when the license becomes inactive;
- providing that a felony conviction under Article 7B of Chapter 14 of the General Statutes (Rape and Other Sex Offenses) shall result in the automatic denial or revocation of a license issued by the Board, and that denial or revocation shall be permanent, and the applicant or licensee shall be ineligible for reapplication, relicensure, reinstatement, or restoration;
- allowing evidence and testimony to be presented at hearings before the Board or a hearing committee in the form of depositions before any person authorized to administer oaths in accordance with the procedure for the taking of depositions in civil actions in the superior court, and allowing, at the discretion of the presiding officer of the hearing, the Board to receive witness testimony at a hearing by means of telephone or videoconferencing;
- amending the definition of “radiology”;
- creating a new criminal offense punishable as a Class C felony for sexual contact or penetration under pretext of medical treatment, if the person does any of the following in the course of that medical treatment: (1) represents to the patient that sexual contact between the person and the patient is necessary or will be beneficial to the patient's health and induces the patient to engage in sexual contact with the person by means of the representation; (2) represents to the patient that sexual penetration between the person and the patient is necessary or will be beneficial to the patient's health and induces the patient to engage in sexual penetration with the person by means of the representation; (3) engages in sexual contact with the patient while the patient is incapacitated; or (4) engages in sexual penetration with the patient while the patient is incapacitated;
- allowing, in the absence of a treating physician, physician assistant, or nurse practitioner in charge of the patient's care at the time of death, the chief medical officer of the hospital or facility in which the death occurred, or a physician performing an autopsy, the death certificate to be completed by any other physician, physician assistant, or nurse practitioner who undertakes reasonable efforts to ascertain the events surrounding the patient's death. A physician, physician assistant, or nurse practitioner, who completes a death certificate in good faith, and without fraud or malice, shall be immune from civil liability or professional discipline; and
- prohibiting the Board from setting fees through the rule-making process. Any fees set pursuant to rules adopted by the Board and applicable on June 1, 2019, remain valid.

**Effective: October 1, 2019, except as otherwise provided.**

- Colleen Kochanek  
NCCEP Legislative Counsel  
Kochanek Law Group  
919.274.0982  
[colleen@kochaneklawgroup.com](mailto:colleen@kochaneklawgroup.com)  
[www.kochaneklawgroup.com](http://www.kochaneklawgroup.com)<sup>i</sup>

Ashley Matlock Perkinson  
Perkinson Law Firm  
919.210.8209  
[ashley@perkinsonlawfirm.com](mailto:ashley@perkinsonlawfirm.com)

Rachel E. Beaulieu  
Rachel E. Beaulieu Law Office, PLLC  
919.896.6296  
[Rachel@BeaulieuEdLaw.com](mailto:Rachel@BeaulieuEdLaw.com)

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