GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

H **1**

HOUSE BILL 288

Short Title: Health Reform Initiatives/HPC. (Public)

Sponsors: Representatives Dickson, Blue, Wright; Alexander, Boyd-McIntyre, Earle, Ives, Rogers, Shaw, and Wainwright.

Referred to: Health and Environment.

February 23, 1995

A BILL TO BE ENTITLED

AN ACT TO ENACT HEALTH CARE REFORM INITIATIVES IN THE AREAS OF PRIMARY CARE, HEALTH CARE FACILITIES, DATA COLLECTION, QUALITY IMPROVEMENT, LOCAL HEALTH PROGRAMS, AND OTHERS, AS RECOMMENDED BY THE NORTH CAROLINA HEALTH PLANNING COMMISSION.

The General Assembly of North Carolina enacts:

PART I – QUALITY IMPROVEMENT COMMISSION

Section 1.1. Chapter 143 of the General Statutes is amended by adding the following new Article to read:

"**ARTICLE 65A.**

"**NORTH CAROLINA QUALITY IMPROVEMENT COMMISSION.**

"**§ 143-615. Purpose.**

The General Assembly recognizes that every resident and community in the State should have access to high quality health services designed to improve health status. The General Assembly further recognizes that to assure high quality health care requires careful monitoring and assessment of the quality of care provided by different health providers in different health settings, as well as monitoring to ensure that quality care is

provided to persons irrespective of health care coverage status. The General Assembly also recognizes that while controlling health care cost is an important component of effective and efficient health care delivery and system reform, quality care is equally important in improving health status in the long and short run. The purpose of this Article is to establish a mechanism for maintaining and enhancing the quality of health services available in this State, and to ensure that efforts to decrease the costs of care are aimed at reducing unnecessary care, excessive administrative costs, and other waste without resulting in a decrease in quality of care and availability of necessary services.

"**§ 143-616. North Carolina Quality Improvement Commission created; members, terms of office; quorum; compensation.**

(a) There is created the North Carolina Quality Improvement Commission. The purpose of the Commission is to conduct necessary activities to assure that health care provided through the public and private health care systems and by health care providers is of sufficient quality to adequately serve the health needs of the citizenry and to improve overall health status of the State's population. The Commission shall be located within the Office of the Secretary, Department of Human Resources, for organizational, budgetary, and administrative purposes.

(b) The North Carolina Quality Improvement Commission shall consist of 12 members, appointed as follows:

(1) Four members appointed by the Governor, at least one of whom is a consumer of health services and is not employed by a health care provider or by the insurance industry, at least one of whom is a physician, and at least one of whom is an employer of 100 or more employees;

(2) Four members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, at least one of whom has experience in health care research, at least one of whom is an employer of less than 100 employees; and at least one of whom is a mid-level health care provider; and

(3) Four members appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, at least one of whom represents the insurance industry or a health maintenance organization, at least one of whom is a representative of the hospital industry, and at least one of whom is a public health professional.

In making appointments to the Commission, the Governor and the General Assembly shall ensure that the Commission's membership reflects the racial and geographic diversity of the State's population.

(c) The Insurance Commissioner, the Secretary of Human Resources, and the Secretary of the Department of Environment, Health, and Natural Resources, and the Chair of the North Carolina Health Data Policy Council, or their designees, shall be ex officio members of the Commission without voting power.

(d) Initial terms of the Governor's appointees shall be three years for two appointees, two years for one appointee, and one year for one appointee. Initial terms of

the General Assembly's appointees shall be three years for two of the appointees recommended by each house and two years for the other two appointees recommended by each house. Thereafter, all terms shall be for two years.

(e) Commission members shall receive no salary as a result of service on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 138-5 and G.S. 138-6, as applicable.

(f) Vacancies in appointments shall be filled by the appointing authority for the unexpired portion of the vacated term.

(g) A majority of the voting members of the Commission shall constitute a quorum.

(h) The Governor shall appoint a member to serve as chair. The Commission shall elect a member to serve as vice-chair.

(i) The Commission shall meet at least once during each calendar quarter upon the call of the chair.

(j) The Commission may hire professional and other staff needed to implement the requirements of this Article.

"**§ 143-617. Powers and duties of the Commission.**

(a) The Commission shall do the following:

(1) Adopt rules as provided in G.S. 143-617.

(2) Monitor quality standards and measurements adopted to implement this Article to determine how well the measurements and standards help improve health status.

(3) Establish a procedure for the development and issuance of report cards to enable consumers and payers to compare the quality and value of services provided by different insurance carriers and health plans, hospitals, and individual providers. There shall be at least two different report cards developed, one for use by consumers and one for use by purchasers of health care coverage. The report cards should be developed using nationally recognized data and may include the following content areas: preventive services, prenatal care, public health measures, acute and chronic disease, mental health, functional status, access to and satisfaction with the system, health improvement programs, cost information, grievance information, enrollment and disenrollment information, and provider satisfaction data. The report cards shall contain reliable and valid outcome variables that are severity adjusted.

(4) Establish minimum quality thresholds that all health insurance carriers and health plans shall be required to meet. Standards for the thresholds shall include structural, process, and outcome requirements, as follows:

a. Structural standards shall include but not be limited to financial solvency, ability to provide a full array of services, and minimum provider:patient ratios;

b. Process standards shall address continuous quality improvement, expertise in the use of high technology and expensive procedures, communications with members, grievance procedures, continuity of care when patients change providers, credentialing requirements, provider compensation disclosure provisions, reporting requirements for provider disenrollment for cause, publicly available utilization review criteria and practice guidelines, enrollment and disenrollment provisions, patient confidentiality protections, informed consent, ombudsman provisions, billing protections for patients, and marketing;

c. Outcome measures shall address health status information and outcome measures, and assessment of how well plans address community health needs; and

(5) Adopt practice guidelines for use by health care providers in North Carolina. In establishing the guidelines, the Commission shall review in consultation with appropriate specialists and adopt, as appropriate, national guidelines currently in use.

(b) In addition to its duties under subsection (a) of this section, the Commission may accept gifts, grants, donations, or contributions from any source. These funds shall be held in a separate account and shall be used solely in furtherance of the purposes of this Article.

(c) The Commission may establish committees to study issues related to the operation of the Commission and to the implementation of this Article. In conducting studies, the Commission shall avail itself of outside experts, where necessary and appropriate to the study.

"**§ 143-618. Rules.**

The Commission shall adopt rules in accordance with Chapter 150B of the General Statutes. The rules shall be written as clearly, concisely, and narrowly as possible to enable the Commission to effectively and efficiently carry out the requirements of this Article. To the extent that rules adopted by the Commission regulate the same purpose, subject matter, and entity as rules adopted by other State agencies, the rules adopted by the Commission shall govern the regulated purpose, subject matter, and entity.

"**§ 143-619. Reports.**

The Commission shall submit annual reports of its work in progress and plans for the future to the General Assembly, the Governor, and the Health Planning Commission. Reports shall be submitted no later than February 1 of each year and shall include the Commission's activities, findings, and recommendations."

PART II – HEALTH CARE FACILITY CHANGES

Sec. 2.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

(1) 'Air ambulance' means aircraft used to provide air transport of sick or injured persons between destinations within the State.

(1a) 'Ambulatory surgical facility' means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least two designated operating rooms and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under G.S. Chapter 131E, Article 6, Part D, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision (1b) and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.

(1b) 'Ambulatory surgical program' means a formal program for providing on a same-day basis those surgical procedures which require local, regional or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to surgery, to be medically unnecessary.

(2) 'Bed capacity' means space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. The term 'bed capacity' also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(2a) 'Bone marrow transplantation services' means the process of infusing bone marrow into persons with diseases to stimulate the production of blood cells.

(2b) 'Burn intensive care services' means services provided in a unit designed to care for patients who have been severely burned.

(2c) 'Campus' means the adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service facility and related health care entities.

(2d) 'Capital expenditure' means an expenditure for a project, including but not limited to the cost of construction, engineering, and equipment

which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase.

~~(2e) 'Cardiac angioplasty equipment' means the cardiac catheterization equipment used in surgery for the restoration, repair, or reconstruction of coronary blood vessels.~~

(2f) 'Cardiac catheterization equipment' means the equipment ~~required to perform diagnostic procedures or therapeutic intervention in which a catheter is introduced into a vein or artery and threaded through the circulatory system to the heart.~~ used to provide cardiac catheterization services.

(2g) 'Cardiac catheterization services' means those procedures, excluding pulmonary angiography procedures, in which a catheter is introduced into a vein or artery and threaded through the circulatory system into the heart specifically to diagnose abnormalities in the motion, contraction, and blood flow of the moving heart or to perform surgical therapeutic interventions to restore, repair, or reconstruct the coronary blood vessels of the heart.

(3) 'Certificate of need' means a written order which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of such project.

(4) Repealed by Session Laws 1993, c. 7, s. 2.

(5) 'Change in bed capacity' means (i) any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(5a) 'Chemical dependency treatment facility' means a public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or substance abuse. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of chemically dependent or substance abusing persons and related services. The facility or unit may be:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5, Chapter 131E, of the General Statutes,

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C,

c. A freestanding facility specializing in treatment of persons who are substance abusers or chemically dependent licensed under Article 1A of General Statutes Chapter 122 or Article 2 of General Statutes Chapter 122C; and may be identified as 'chemical dependency, substance abuse, alcoholism, or drug abuse treatment units,' 'residential chemical dependency, substance abuse, alcoholism or drug abuse facilities,' 'social setting detoxification facilities' and 'medical detoxification facilities,' or by other names if the purpose is to provide treatment of chemically dependent or substance abusing persons, but shall not include halfway houses or recovery farms.

(5b) 'Chemical dependency treatment beds' means beds that are licensed for detoxification or for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance abuse are chemical dependency treatment beds.

(5c) 'Computed tomography (CT) scanner' means an imaging machine that combines the information generated by a scanning X-ray source and detector system with a computer to reconstruct a cross-sectional image of the full body, including the head.

(6) 'Department' means the North Carolina Department of Human Resources.

(7) To 'develop' when used in connection with health services, means to undertake those activities which will result in the offering of institutional health service or the incurring of a financial obligation in relation to the offering of such a service.

~~(7a) 'Diagnostic center' means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~

(7b) 'Expedited review' means the status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:
a. The review is not competitive.
b. The proposed capital expenditure is less than five million dollars ($5,000,000).
c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.
d. The agency has not determined that a public hearing is in the public interest.

(7c) 'Gamma knife' means equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery.

(8), (9) Repealed by Session Laws 1987, c. 511, s. 1.

(9a) 'Health service' means an organized, interrelated medical, diagnostic, therapeutic, and/or rehabilitative activity that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. 'Health service' does not include administrative and other activities that are not integral to clinical management.

(9b) 'Health service facility' means a hospital; psychiatric facility; rehabilitation facility; long term care facility; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for the mentally retarded; home health agency office; chemical dependency treatment facility; ~~diagnostic center; oncology treatment center; hospice,~~ hospice; hospice inpatient ~~facility,~~ facility; hospice residential care facility; and ambulatory surgical facility.

(9c) 'Health service facility bed' means a bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing care beds; (v) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; and (viii) hospice residential care facility beds.

(10) 'Health maintenance organization (HMO)' means a public or private organization which has received its certificate of authority under Article 67 of Chapter 58 of the General Statutes and which either is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act or:
a. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X ray, emergency and preventive services, and out-of-area coverage;

b. Is compensated, except for copayments, for the provision of the basic health care services listed above to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and

c. Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organizations, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(10a) 'Heart-lung bypass machine' means the equipment used to perform extra-corporeal circulation and oxygenation during surgical procedures.

(11) Repealed by Session Laws 1991, c. 692, s. 1.

(12) 'Home health agency' means a private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.

'Home health services' means items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and except for paragraph e. of this subdivision, in a place of temporary or permanent residence used as the individual's home as follows:

a. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse;

b. Physical, occupational or speech therapy;

c. Medical social services, home health aid services, and other therapeutic services;

d. Medical supplies, other than drugs and biologicals and the use of medical appliances;

e. Any of the foregoing items and services which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in his home, or which are furnished at such facility while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

(13) 'Hospital' means a public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E-77 of the General Statutes.

(13a) 'Hospice' means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(13b) 'Hospice inpatient facility' means a freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting. For purposes of this Article only, a hospital which has a contractual agreement with a licensed hospice to provide inpatient services to a hospice patient as defined in G.S. 131E-201(4) and provides those services in a licensed acute care bed is not a hospice inpatient facility and is not subject to the requirements in G.S. 131E-176(5)(ii) for hospice inpatient beds.

(13c) 'Hospice residential care facility' means a freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.

(14) Repealed by Session Laws 1987, c. 511, s. 1.

(14a) 'Intermediate care facility for the mentally retarded' means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with mental retardation, autism, cerebral palsy, epilepsy or related conditions.

(14b) Repealed by Session Laws 1991, c. 692, s. 1.

(14b1) 'Linear accelerator' means a machine used to produce ionizing radiation in excess of one million electron volts in the form of a beam of electrons or photons to treat cancer patients.

(14c) 'Lithotriptor' means extra-corporeal shock wave technology used to treat persons with kidney stones and gallstones.

(14d) 'Long term care facility' means a health service facility whose bed complement of health service facility beds is composed principally of nursing care facility beds.

(14e) 'Magnetic resonance imaging scanner' means medical imaging equipment that uses nuclear magnetic resonance.

(14f) 'Major medical equipment' means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~ five hundred thousand dollars ($500,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~ five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section.

(15) Repealed by Session Laws 1987, c. 511, s. 1.

(15a) 'Multispecialty ambulatory surgical program' means a formal program for providing on a same-day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery.

(15b) 'Neonatal intensive care services' means those services provided by a health service facility to high-risk newborn infants who require constant nursing care, including but not limited to continuous cardiopulmonary and other supportive care.

(16) 'New institutional health services' means any of the following:

a. The construction, development, or other establishment of a new health service facility.

b. The obligation by any person of a capital expenditure exceeding two million dollars ($2,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds two million dollars ($2,000,000).

c. Any change in bed capacity as defined in G.S. 131E-176(5).

d. The offering of dialysis services or home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

e. A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital expenditure amount or the addition of a health service that is to be located in the facility, or portion thereof, that was constructed or developed in the project.

f. The development or offering of a health service as listed in this subdivision by or on behalf of any person:

1. Bone marrow transplantation services.
2. Burn intensive care services.
2a. Cardiac catheterization services.
3. Neonatal intensive care services.
4. Open-heart surgery services.
5. Solid organ transplantation services.

f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any ~~person:~~ person, whether the equipment is acquired as a complete, assembled unit or is acquired piecemeal. If the equipment is acquired piecemeal, it is considered to be required on the date that the components are assembled:

1. Air ambulance.
~~2. Cardiac angioplasty equipment.~~
3. Cardiac catheterization equipment.
3a. Computed tomography scanner.
4. Gamma knife.
5. Heart-lung bypass machine.
5a. Linear accelerator.
6. Lithotriptor.
7. Magnetic resonance imaging scanner.
8. Positron emission tomography scanner.
9. Radiation therapy equipment.
10. Simulator.

g. to k. Repealed by Session Laws 1987, c. 511, s. 1.

l. The purchase, lease, or acquisition of any health service facility, or portion thereof, or a controlling interest in the health service facility or portion thereof, if the health service facility was

developed under a certificate of need issued pursuant to G.S. 131E-180.

m. Any conversion of nonhealth service facility beds to health service facility beds.

n. The construction, development or other establishment of a hospice, hospice inpatient facility, or hospice residential care facility;

o. The opening of an additional office by an existing home health agency within its service area as defined by rules adopted by the Department; or the opening of any office by an existing home health agency outside its service area as defined by rules adopted by the Department.

p. The acquisition by purchase, donation, lease, transfer, or comparable arrangement by any person of major medical equipment.

q. The relocation of a health service facility from one service area to another.

r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.

r1. Any increase in the number of operating rooms in a hospital or licensed ambulatory surgical facility or any increase in the number of recovery rooms in a licensed ambulatory surgical facility.

s. ~~The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use in North Carolina prior to the adoption of this provision, if such equipment would otherwise be subject to review in accordance with G.S. 131E-176(16)(f1.) or G.S. 131E-176(16)(p) if it had been acquired in North Carolina.~~ The importing of major medical equipment or medical equipment listed in G.S. 131E-176(16)(f1) into the State, for use in the State, if the equipment was not acquired pursuant to a certificate of need issued by the Department.

t. An agreement by any person to provide a site for the operation of major medical equipment or medical equipment listed in G.S. 131E-176(16)(f1). A certificate of need that authorizes such an agreement is valid for all subsequent agreements for comparable medical equipment at the same site, unless there is a lapse of more than six months between agreements.

(17) 'North Carolina State Health Coordinating Council' means the Council that prepares, with the Department of Human Resources, the State Medical Facilities Plan.

(17a) 'Nursing care' means:

a. Skilled nursing care and related services for residents who require medical or nursing care;

b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

These are services which are not primarily for the care and treatment of mental diseases.

(18) To 'offer,' when used in connection with health services, means that the person holds himself out as capable of providing, or as having the means for the provision of, specified health services.

~~(18a) 'Oncology treatment center' means a facility, program, or provider, other than an existing health service facility that provides services for diagnosis, evaluation, or treatment of cancer and its aftereffects or secondary results and for which the total cost of all the medical equipment utilized by the center, exceeds two hundred fifty thousand dollars ($250,000). In determining whether costs are more than two hundred fifty thousand dollars ($250,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the facility, program, or provider shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.~~

(18b) 'Open-heart surgery services' means the provision of surgical procedures that utilize a heart-lung bypass machine during surgery to correct cardiac and coronary artery disease or defects.

(19) 'Person' means an individual, a trust or estate, a partnership, a corporation, including associations, joint stock companies, and insurance companies; the State, or a political subdivision or agency or instrumentality of the State.

(19a) 'Positron emission tomography scanner' means equipment that utilizes a computerized radiographic technique that employs radioactive substances to examine the metabolic activity of various body structures.

(20) 'Project' or 'capital expenditure project' means a proposal to undertake a capital expenditure that results in the offering of a new institutional health service as defined by this Article. A project, or capital expenditure project, or proposed project may refer to the project from its earliest planning stages up through the point at which the specified new

institutional health service may be offered. In the case of facility construction, the point at which the new institutional health service may be offered must take place after the facility is capable of being fully licensed and operated for its intended use, and at that time it shall be considered a health service facility.

(21) 'Psychiatric facility' means a public or private facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes and which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(21a) 'Radiation therapy equipment' means a single unit or a single system of components with related functions that is used to deliver precisely controlled and monitored doses of radiation to a defined volume of tumor-bearing tissue within a patient and that costs more than two hundred fifty thousand dollars ($250,000). In determining whether the radiation therapy equipment costs more than two hundred fifty thousand dollars ($250,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the radiation therapy equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

(22) 'Rehabilitation facility' means a public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent, professional supervision.

(22a) 'Replacement equipment' means equipment that costs less than two million dollars ($2,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than two million dollars ($2,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

(23) Repealed by Session Laws 1991, c. 692, s. 1.

(24) Repealed by Session Laws 1993, c. 7, s. 2.

(24a) 'Service area' means the area of the State, as defined in the State Medical Facilities Plan or in rules adopted by the Department, which receives services from a health service facility.

(24a1) 'Simulator' means a machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient.

(24b) 'Solid organ transplantation services' means the provision of surgical procedures and the interrelated medical services that accompany the surgery to remove an organ from a patient and surgically implant an organ from a donor.

(24c) 'Specialty ambulatory surgical program' means a formal program for providing on a same-day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and authorized by its certificate of need.

(25) 'State Medical Facilities Plan' means the plan prepared by the Department of Human Resources and the North Carolina State Health Coordinating Council, and approved by the Governor.

(26) Repealed by Session Laws 1983 (Regular Session, 1984), c.1002, s. 9.

(27) Repealed by Session Laws 1987, c. 511, s. 1."

Sec. 2.2. G.S. 131E-180 reads as rewritten:

"**§ 131E-180. Health maintenance organization.**

(a) ~~Subject to the provisions of subsection (b) of this section, no inpatient health service facility controlled, directly or indirectly, by a health maintenance organization (HMO), or combination of HMOs, shall offer or develop new institutional health services without first obtaining a certificate of need from the Department. This section shall not be construed as requiring that a certificate of need be obtained before an HMO is established.~~

~~(b) The requirements of subsection (a) of this section shall not apply to any person who receives an exemption under this subsection. In order to receive an exemption an application must be submitted to the Department and the appropriate health systems agency or agencies. The application shall be on forms prescribed by the Department and contain the information required by the Department. The application shall be submitted at a time and in a manner prescribed by the rules of the Department. The Department may grant an exemption if it finds that the applicant is qualified or will be qualified on the date the activity is undertaken. Any of the following are qualified applicants:~~

~~(1) An HMO or combination of HMOs, if (i) the HMO or combination of HMOs has an enrollment of at least 50,000 individuals in its service area, (ii) the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals, and (iii) at least seventy-five percent (75%) of the patients who can be reasonably expected to receive the health service will be individuals enrolled in the HMO or HMOs in combination; or~~

~~(2) A health service facility, or portion thereof, if (i) the facility primarily provides or will provide inpatient health services, (ii) the facility is or~~

~~will be controlled, directly or indirectly, by an HMO or combination of HMOs with an enrollment of at least 50,000 individuals in its service area, (iii) the facility is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals, and (iv) at least seventy-five percent (75%) of the patients who can be reasonably expected to receive the health service will be individuals enrolled with the HMO or HMOs in combination; or~~

~~(3) A health service facility, or portion thereof, if (i) the facility is or will be leased by an HMO or combination of HMOs with an enrollment of at least 50,000 individuals in its service area and on the date the application for exemption is submitted at least 15 years remain on the lease, (ii) the facility is or will be geographically located so that the service will be reasonably accessible to the enrolled individuals, and (iii) at least seventy-five percent (75%) of the patients who can be reasonably expected to receive the health service will be individuals enrolled with the HMO or HMOs in combination.~~

~~(c) If a fee-for-service component of an HMO or combination of HMOs qualifies for an exemption under subsection (b) of this section, then it must be granted an exemption.~~

~~(d) In reviewing certificate of need applications submitted pursuant to this section, the Department shall not deny the application solely because the proposal is not addressed in the applicable health systems plan, annual implementation plan or State Health Plan.~~

~~(e) Notwithstanding the review criteria of G.S. 131E-183(a), if an HMO or a health service facility which is controlled, directly or indirectly, by an HMO applies for a certificate of need, the Department may grant the certificate if it finds, in accordance with G.S. 131E-183(a)(10), that (i) granting the certificate is required to meet the needs of the members of the HMO and of the new members which the HMO can reasonably be expected to enroll, and (ii) the HMO is unable to provide, through services or facilities which can reasonably be expected to be available to the HMO, its health services in a reasonable and cost-effective manner which is consistent with the basic method of operations of the HMO and which makes these services available on a long-term basis through physicians and other health professionals associated with it.~~

Notwithstanding the review criteria of G.S. 131E-183(a)(1), if an eligible health maintenance organization (HMO) applies for a certificate of need for major medical equipment or equipment listed in G.S. 131E-176(16)(f1), the Department may grant the certificate if:

(1) The applicant demonstrates that the application is conforming with all other applicable review criteria; and

(2) The applicant demonstrates, in accordance with G.S. 131E-183(a)(10), that (i) the equipment is required to meet the needs of the members of the HMO and of the new members that the HMO can reasonably be expected to enroll within three years from the date the application is

submitted, and (ii) the HMO is unable to provide, through services or facilities that can reasonably be expected to be available to the HMO, its health services in a reasonable and cost-effective manner that is consistent with the basic method of operations of the HMO and that makes these services available on a long-term basis through physicians and other health professionals associated with it.

(b) A health maintenance organization (HMO) is an eligible HMO under this section if:

(1) The HMO has an enrollment of at least 50,000 members in its services area on the date the application is submitted;

(2) The proposed equipment will be centrally located so that it will be reasonably accessible to enrolled members; and

(3) At least seventy-five percent (75%) of the patients projected to be served with the equipment will be enrolled members of the HMOs."

Sec. 2.3. G.S. 131E-192.1 reads as rewritten:

"**§ 131E-192.1. Findings.**

The General Assembly of North Carolina makes the following findings:

(1) That technological and scientific developments in ~~hospital~~ health care have enhanced the prospects for further improvement in the quality of care provided by North Carolina ~~hospitals~~ health service facilities and health care providers to North Carolina citizens.

(2) That the cost of improved technology and improved scientific methods for the provision of ~~hospital~~ health care contributes substantially to the increasing cost of ~~hospital care.~~ care by health service facilities and health care providers. Cost increases make it increasingly difficult for ~~hospitals~~ health service facilities and health care providers in rural areas of North Carolina to offer care.

(3) That changes in federal and State regulations governing ~~hospital~~ health service facility and health care provider operation and reimbursement have constrained the ability of ~~hospitals~~ health service facilities and health care providers to acquire and develop new and improved machinery and methods for the provision of ~~hospital-related~~ health service facility-related and health care provider-related care.

(4) That cooperative agreements among ~~hospitals~~ health service facilities and between ~~hospitals~~ health service facilities, health care providers and others for the provision of health care services may foster improvements in the quality of health care for North Carolina citizens, moderate increases in cost, improve access to needed services in rural areas of North Carolina, and enhance the likelihood that smaller ~~hospitals~~ health service facilities and health care providers in North Carolina will remain ~~open~~ available in beneficial service to their communities.

(5) That ~~hospitals~~ health service facilities and health care providers are often in the best position to identify and structure cooperative

arrangements that enhance quality of care, improve access, and achieve cost-efficiency in the provision of care.

(6) That federal and State antitrust laws may prohibit or discourage cooperative arrangements that are beneficial to North Carolina citizens despite their potential for or actual reduction in competition and that ~~such~~ these agreements should be permitted and encouraged.

(7) That competition as currently mandated by federal and State antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements ~~between hospitals, or between hospitals and others,~~ among health service facilities, or between health service facilities, health care providers, and others that are beneficial to North Carolina citizens when the benefits of cooperative agreements outweigh their disadvantages caused by their potential or actual adverse effects on competition.

(8) That regulatory as well as judicial oversight of cooperative agreements should be provided to ensure that the benefits of cooperative agreements permitted and encouraged in North Carolina outweigh any disadvantages attributable to any reduction in competition likely to result from the agreements."

Sec. 2.4. G.S. 131E-192.2 reads as rewritten:

"**§ 131E-192.2. Definitions.**

The following definitions apply in this Article:

(1) 'Attorney General' means the Attorney General of the State of North Carolina or any attorney on his or her staff to whom the Attorney General delegates authority and responsibility to act pursuant to this Article.

(2) 'Cooperative agreement' means an agreement among two or more ~~hospitals,~~ health service facilities, or between a ~~hospital~~ health service facility, health care provider, and any other person, for the sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities, or medical, diagnostic, or laboratory facilities or equipment, or procedures or other services traditionally offered by ~~hospitals.~~ health service facilities and health care providers. Cooperative agreement shall not include any agreement by which ownership over substantially all of the stock, assets, or activities of one or more previously licensed and operating ~~hospitals~~ health service facilities is transferred nor any agreement that would permit self-referrals of patients by a health care provider that is otherwise prohibited by law.

(3) 'Department' means the Department of Human Resources.

(4) 'Federal or State antitrust laws' means any and all federal or State laws prohibiting monopolies or agreements in restraint of trade, including the federal Sherman Act, Clayton Act, Federal Trade Commission Act, and

North Carolina laws codified in Chapter 75 of the General Statutes that prohibit restraints on competition.

(5) ~~'Hospital' means any hospital~~ 'Health service facility' means any health service facility as defined under G.S. 131E-176(9b) that is required to be licensed under ~~Chapters 131E or~~ this Chapter or under Chapter 122C of the General Statutes.

(5a) 'Health care provider' means a person defined as a health care provider under G.S. 90-405(7).

(6) 'Person' means any individual, firm, partnership, corporation, association, public or private institution, political subdivision, or government agency."

Sec. 2.5. G.S. 131E-192.3 reads as rewritten:

"**§ 131E-192.3. Certificate of public advantage; application.**

(a) A ~~hospital~~ health service facility or a health care provider and any person who is a party to a cooperative agreement with a ~~hospital~~ health service facility may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any State antitrust law if a certificate of public advantage is issued for the cooperative agreement, or in the case of activities to negotiate or enter into a cooperative agreement, if an application for a certificate of public advantage is filed in good faith. It is the intention of the General Assembly that immunity from federal antitrust laws shall also be conferred by this statute and the State regulatory program that it establishes.

(b) Parties to a cooperative agreement may apply to the Department for a certificate of public advantage governing that cooperative agreement. The application must include an executed written copy of the cooperative agreement or letter of intent with respect to the agreement, a description of the nature and scope of the activities and cooperation in the agreement, any consideration passing to any party under the agreement, and any additional materials necessary to fully explain the agreement and its likely effects. A copy of the application and all additional related materials shall be submitted to the Attorney General at the same time the application is submitted to the Department."

Sec. 2.6. G.S. 131E-192.4 reads as rewritten:

"**§ 131E-192.4. Procedure for review; standards for review.**

(a) The Department shall review an application in accordance with the standards set forth in subsection (b) of this section and shall hold a public hearing with the opportunity for the submission of oral and written public comments in accordance with rules adopted by the Department. The Department shall determine whether the application should be granted or denied within 90 days of the date the application is filed. The Department may extend the review period for a specified period of time upon notice to the parties.

(b) The Department shall determine that a certificate of public advantage should be issued for a cooperative agreement if it determines that an applicant has demonstrated by clear and convincing evidence that the benefits likely to result from the agreement

outweigh the disadvantages likely to result from a reduction in competition from the agreement.

In evaluating the potential benefits of a cooperative agreement, the Department shall consider whether one or more of the following benefits may result from the cooperative agreement:

(1) Enhancement of the quality of ~~hospital~~ health service facility and ~~hospital-related~~ health service facility-related care provided to North Carolina citizens.

(2) Preservation of ~~hospital~~ health service facilities or health care providers in geographical proximity to the communities traditionally served by those facilities.

(3) Lower costs of, or gains in, the efficiency of delivering ~~hospital~~ health service facility or health care provider services.

(4) Improvements in the utilization of ~~hospital~~ health service facility or health care provider resources and equipment.

(5) Avoidance of duplication of ~~hospital~~ health service facility or health care provider resources.

(6) The extent to which medically underserved populations are expected to utilize the proposed services.

In evaluating the potential disadvantages of a cooperative agreement, the Department shall consider whether one or more of the following disadvantages may result from the cooperative agreements:

(1) The extent to which the agreement may increase the costs or prices of health care at a ~~hospital~~ health service facility or by a health care provider ~~which~~ that is party to the cooperative agreement.

(2) The extent to which the agreement may have an adverse impact on patients in the quality, availability, and price of health care services.

(3) The extent to which the agreement may reduce competition among the parties to the agreement and the likely effects thereof.

(4) The extent to which the agreement may have an adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents, or other health care payors to negotiate optimal payment and service arrangements with ~~hospitals,~~ health service facilities, physicians, allied health care professionals, or other health care providers.

(5) The extent to which the agreement may result in a reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, ~~hospitals.~~ health service facilities.

(6) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition.

In making its determination, the Department may consider other benefits or disadvantages that may be identified."

Sec. 2.7. G.S. 131E-192.13 reads as rewritten:

"**§ 131E-192.13. Effects of certificate of public advantage; other laws.**

(a) Activities conducted pursuant to a cooperative agreement for which a certificate of public advantage has been issued are immunized from challenge or scrutiny under State antitrust laws. In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is filed in good faith shall be immune from challenge or scrutiny under State antitrust laws, regardless of whether a certificate is issued. It is the intention of the General Assembly that this Article shall also immunize covered activities from challenge or scrutiny under federal antitrust law.

(b) Nothing in this Article shall exempt ~~hospitals~~ health service facilities or other health care providers from compliance with State or federal laws governing certificate of need, licensure, or other regulatory requirements.

(c) Any dispute among the parties to a cooperative agreement concerning its meaning or terms is governed by normal principles of contract law."

Sec. 2.8. G.S. 160A-20 reads as rewritten:

"**§ 160A-20. Security interests.**

(a) Units of local government, as defined in subsection (h), may purchase or finance the purchase of real or personal property by installment contracts that create in the property purchased a security interest to secure payment of the purchase price to the seller or to an individual or entity advancing moneys or supplying financing for the purchase transaction.

(b) Units of local government, as defined in subsection (h), may finance the construction or repair of fixtures or improvements on real property by contracts that create in the fixtures or improvements, or in all or some portion of the property on which the fixtures or improvements are located, or in both, a security interest to secure repayment of moneys advanced or made available for such construction or repair.

(c) Units of local government, as defined in subsection (h), may use escrow accounts in connection with the advance funding of transactions authorized by this section, whereby the proceeds of such advance funding are invested pending disbursement.

(d) No contract entered into under this section may contain a nonsubstitution clause that restricts the right of a unit of local government to:

(1) Continue to provide a service or activity; or

(2) Replace or provide a substitute for any fixture, improvement, project, or property financed or purchased pursuant to such contract.

(e) A contract entered into under this section is subject to approval by the Local Government Commission under Article 8 of Chapter 159 of the General Statutes if it:

(1) Meets the standards set out in G.S. 159-148(a)(1), 159-148(a)(2), and 159-148(a)(3), or involves the construction or repair of fixtures or improvements on real property; and

(2) Is not exempted from the provisions of that Article by one of the exemptions contained in G.S. 159-148(b).

(f) No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this section, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this section.

(g) Before entering into a contract under this section involving real property, a unit of local government shall hold a public hearing on the contract. A notice of the public hearing shall be published once at least 10 days before the date fixed for the hearing. Any contract entered into under this section by a public hospital as a unit of local government shall be subject to the approval of the Local Government Commission pursuant to Article 8 of Chapter 159 of the General Statutes.

(h) As used in this section, the term 'unit of local government' means any of the following:

(1) A county.

(2) A city.

(3) A water and sewer authority created under Article 1 of Chapter 162A of the General Statutes.

(4) An airport authority whose situs is entirely within a county that has (i) a population of over 120,000 according to the most recent federal decennial census and (ii) an area of less than 200 square miles.

(5) An airport authority in a county in which there are two incorporated municipalities with a population of more than 65,000 according to the most recent federal decennial census.

(6) A local school administrative unit (i) that is located in a county that has a population of over 90,000 according to the most recent federal decennial census and (ii) whose board of education is authorized to levy a school tax.

(7) An area mental health, developmental disabilities, and substance abuse authority, acting in accordance with G.S. 122C-147.

(8) A public hospital as defined in Part 4 of Article 3 of Chapter 159 of the General Statutes."

Sec. 2.9. (a) The Department of Human Resources, in consultation with the North Carolina Hospital Association, the North Carolina College of Emergency Physicians, and the North Carolina Association of Paramedics, shall study the feasibility of providing financial incentives for sound emergency medical systems in underserved areas where there are no full-service hospitals. The study shall include what incentives might be needed, if any, to help maintain needed emergency services when hospital beds are reconfigured. The Department shall report its findings and recommendations to the North Carolina Health Planning Commission on or before October 1, 1996. The report may include proposed legislation for introduction in the 1997 General Assembly.

(b) The Department of Human Resources shall undertake the activities are necessary to encourage the optimization, redirection, or conversion of structurally inefficient hospitals and the elimination of unneeded services.

PART III – COMMUNITY HEALTH INITIATIVES

Sec. 3.1. Article 5 of Chapter 153A of the General Statutes is amended by adding a new Part to read:

"**PART 1A. HUMAN RESOURCE AUTHORITIES AUTHORIZED.**

"**§ 153A-78. Statement of purpose.**

This Part is enacted to give counties or multicounty consortia the authority to merge the funding, administration, and delivery of social services, public health services, and mental health services.

It is the intent of the General Assembly that services be provided that are more responsive to the needs of children, families, and adults, more preventive, and more supportive of families; that services be financed in a way that supports a more flexible, individualized, and cost-effective approach; and that services be organized and governed so that they are more effective and more coherent in carrying out a community's agenda on behalf of children, adults, and families, and are more rooted within local communities.

"**§ 153A-78.1. Human Resource Authority; creation.**

(a) A county or group of counties may establish, in accordance with this Part, a human resource authority to absorb the functions of the county departments of social services, the county health departments, and the area mental health, developmental disabilities, and substance abuse authorities. Such functions may also include those of the county if direct control by the county of that function had previously been assumed under G.S. 153A-77. If the county is part of a district health department, then the functions of that district health department may be absorbed if all the counties in the district participate in creation of the human resource authority, except that a county may participate in the human resource authority if it withdraws from the district health department in accordance with G.S. 130A-38. If the county is part of a multicounty area mental health, developmental disabilities, and substance abuse authority, then the functions of that area mental health, developmental disabilities, and substance abuse authority may be absorbed if all the counties in the area mental health, developmental disabilities, and substance abuse authority, participate in creation of the human resource authority, except that a county may participate in the human resource authority if it withdraws from the area mental health, developmental disabilities, and substance abuse authority, with prior notice to remaining counties. No withdrawal will be effective before the beginning of the next fiscal year.

(b) A human resource authority is a local political subdivision of the State, except that if it is an authority for a single county, the board of commissioners of that human resource authority may provide that it is a department of the county for the purpose of Chapter 159 of the General Statutes. For the purpose of Article 1 of Chapter 159 of the General Statutes, a human resource authority is a public authority.

(c) In order to form the human resource authority, if the function to be absorbed is either or both of the county department of social services or the area mental health, developmental disabilities, and substance abuse authority, then the formation must be approved by the county board of commissioners and the Secretary of Human Resources in accordance with rules adopted by that Secretary. In order to form the human resource authority, if the function to be absorbed is that of the local health department, then the formation must be approved by the county board of commissioners and the Secretary of Environment, Health, and Natural Resources in accordance with rules adopted by that Secretary.

(d) Before approving participation in a human resource authority, the county board of commissioners shall hold a public hearing with notice published at least 10 days before the hearing.

(e) If the human resource authority absorbs the functions of the board of social services, then that board is dissolved and the county department of social services is merged into the human resource authority as provided by the resolution establishing the human resource authority. If the human resource authority absorbs the functions of the county board of health, then that board is dissolved and the county health department is merged into the human resource authority as provided by the resolution establishing the human resource authority. If the human resource authority absorbs the functions of a single-county area board of mental health, developmental disabilities, and substance abuse, then that area board of mental health, developmental disabilities, and substance abuse is dissolved and is merged into the human resource authority as provided by the resolution establishing the human resource authority. In the case where all the counties of a district board of health or multicounty area board of mental health, developmental disabilities, and substance abuse have the function absorbed by the human resource authority, then the district board of health or multicounty area board of mental health, developmental disabilities, and substance abuse are dissolved and merged into the human resource authority as provided by the resolution establishing the human resource authority. If not all of the counties in a district board of health or a multicounty area board of mental health, developmental disabilities, and substance abuse have their functions absorbed by the human resource authority, then the resolution establishing the human resource authority shall provide for an orderly transition and disposition of assets, contract, obligations, and liabilities.

"**§ 153A-78.2. Authority; membership.**

Membership of the human resource authority board shall be 12 members, of which no less than three members shall be consumers of services provided, at least one of whom shall be from a low-income family. At least one member of the board shall be a representative of a nonprofit provider of health or human services. The members of the governing board shall be appointed by the county boards of commissioners of the affected counties. The resolution establishing boards serving more than one county shall assure balanced representation of the counties being served. No term of office may be for greater than four years, and no board member may serve more than two consecutive terms.

"**§ 153A-78.3. Powers of authority.**

(a) A human resource authority shall exercise all powers required to be exercised by, and may exercise all powers permitted to be exercised by, the agency it absorbs. Such powers shall be exercised in the manner provided by law and implementing regulations, except that references to the specific county board of social services, local board of health, or area board of mental health, developmental disabilities, and substance abuse shall instead be treated as references to the human resource authority. References in those laws to specific officers or employees of the county board of social services, local board of health, or area board of mental health, developmental disabilities, and substance abuse shall instead be treated as the appropriate officer or employee of the human resource authority board.

(b) Within the limitations allowed by law, human resource authority boards shall provide, or shall assure the provision of, services which formerly were provided under authority of county boards of social services, local boards of health, or area boards of mental health, developmental disabilities, and substance abuse services. Nothing in this Part shall restrict or limit the authority of human resource authority boards to contract for the provision of services in a manner provided by law. Boards shall make every effort to coordinate and integrate the delivery of services in a cost-effective manner.

"**§ 153A-78.4. Single portal of entry.**

(a) A human resource authority may develop a single portal of entry, a consolidated case management system, and a common database in order to provide services efficiently. Nothing in this section shall be construed to abrogate a person's right to confidentiality as provided by law. Actions under this section must conform to rules adopted by the Social Services Commission, the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Commission for Health Services, and must be approved by the Secretaries of Human Resources and Environment, Health, and Natural Resources.

(b) Health and human services boards shall coordinate their services with State initiatives designed to automate, simplify, improve, and otherwise coordinate the delivery of health and human services.

(c) The Department of Human Resources and the Department of Environment, Health, and Natural Resources may adopt rules for accountability which provide incentives, including less restrictive funding, for boards which meet or exceed prescribed outcome goals for children, adults, and families, as determined in a long-range plan submitted to each Department under programs and rules it administers. Each Department may adopt rules which set forth the planning, submission, and plan approval process.

"**§ 153A-78.5. Financing.**

A human resource authority shall be financed by counties, and, if provided by law, by cities, under the same provisions of law as the functions absorbed by the human resource authority were financed."

Sec. 3.2. (a) The Department of Environment, Health, and Natural Resources, in consultation with the Department of Human Resources, the Department of Insurance, and the North Carolina Health Planning Commission shall develop a plan for the

establishment of community health districts to coordinate the public and private health systems in this State. The plan shall provide for the establishment of six to twenty community health districts. The plan shall further provide that each community health district shall have the following responsibilities:

(1) Coordinating private and publicly supported medical care services and public health services in the district;

(2) Measuring health status indicators for populations within each district and producing annual public reports describing the health status of the district;

(3) Planning, resource development and allocation, program evaluation and monitoring of health care and public health expenditures, and the use of health care resources;

(4) Ensuring that where shortages of health care personnel or significant health risks exist, these shortages and risks be addressed either through cooperative and collaborative efforts among public/private agencies, or, where such efforts are not made, through efforts of the community health district;

(5) Monitoring private insurance carriers and health plans operating in the community to assess how well the carrier or health plan is helping address community health needs; report findings to Department of Insurance for use in licensure decisions; and

(6) Assessing how well publicly funded health agencies, including public health and mental health, address community health priorities, and making recommendations to the appropriate State agencies on the distribution of public funds.

(b) The Department of Environment, Health, and Natural Resources shall report its progress on the development of community health districts to the General Assembly and to the North Carolina Health Planning Commission not later than October 1, 1995. The Department shall submit its final report to the General Assembly and the North Carolina Health Planning Commission on or before May 1, 1996.

Sec. 3.3. The Division of Aging, Department of Human Resources, shall submit a plan to the 1995 General Assembly, Regular Session 1996, for the consolidation of funding by all health and social service agencies of the State that would facilitate in more effective provision of home and community care. The plan shall be submitted on or before May 1, 1996.

Sec. 3.4. (a) Every county in the State shall develop an interagency plan to coordinate and develop needed support services in the county that will assist individuals or families to access and maximize the effectiveness of health services available. The plan shall be developed with the participation of health and social service agencies in the county, including local health departments, area mental health programs, departments of social services, public schools, local interagency councils, health advocacy organizations, Smart Start partnerships, and individual consumers. Each plan shall be developed to ensure that the support services are made available in a more structured, systematic, and

efficient manner and shall include coordinated approaches for providing outreach, interpreter services, transportation, and other linkages to care coordination systems in place to serve special populations as that term is defined under G.S. 131G-2-5. As used in this section, the term 'support services' shall include but is not limited to transportation, language translation, and case management.

(b) The Department of Human Resources and the Department of Environment, Health, and Natural Resources shall establish a program to assist each and every county in coordinating and developing the interagency plan required under subsection (a) of this section.

PART IV – HEALTH DATA COLLECTION AND ASSESSMENT

Sec. 4.1. Effective October 1, 1995, Article 11 of Chapter 131E of the General Statutes is repealed.

Sec. 4.2. Effective October 1, 1995, the General Statutes are amended by adding the following new Chapter to read:

"CHAPTER 131G.

"HEALTH DATA COORDINATION AND ASSESSMENT.

"ARTICLE 1.

"HEALTH DATA POLICY COUNCIL.

"**§ 131G-1-1. Title and purpose.**

(a) This Article shall be known as the 'North Carolina Health Data Coordination and Assessment Act.'

(b) The General Assembly recognizes that in order to improve the quality of and access to health services and at the same time to contain costs of these services to the citizens of this State, policy makers and health managers will need more sophisticated information support to make effective decisions. The General Assembly further finds that such decisions affect resource allocation, plan performance, and the implementation of new programs to fill gaps in the State's health delivery system. Moreover, in order to ensure that the consumer is better informed and to facilitate changes occurring within the health care systems market, standardized provider performance information must be collected and made available to the public. Also, researchers will need a broader range of detailed health data in order to identify trends and establish clinically based performance measures, and practitioners and clinicians will need more timely access to information related to patient history and current treatment. It is the intent and purpose of this Act to establish mechanisms for improving data collection and enhancing information systems such that ultimately the State will have in place a health data infrastructure that will lead to better public policy decision making and a more efficient private market to provide access to quality health care for all North Carolinians.

"**§ 131G-1-2. Health Data Policy Council created.**

There is created the North Carolina Health Data Policy Council whose purpose is to set policy and establish goals and guidelines for health data processing, collection, and analysis activities in the private and public sectors. The Council shall be located in the

Department of Human Resources for organizational, budgetary, and administrative purposes only. The Council's primary responsibilities are to:

(1) Coordinate all health data management activities of the State.

(2) Provide for ongoing assessment of emerging technologies and applications which support deliberate and continued advancement toward the State's goal to establish a health information structure that supports a cost-effective and quality health care delivery system.

(3) Conduct activities which facilitate the utilization of data by coordinating access by multiple users of data which may be collected by several sources.

(4) Advise the North Carolina Health Planning Commission on emerging issues related to health data policy.

(5) Conduct studies and reviews to ensure that duplication in the collection of health data is eliminated.

(6) Study and make recommendations on the release of provider performance information, specifically as it relates to practice patterns and provider liability.

(7) Adopt and monitor guidelines to ensure the accuracy and integrity of data collected, and to protect patient privacy in accordance with State and federal law.

(8) In consultation with the North Carolina Health Care Database, develop standards for the licensure of health transaction clearinghouses such that on and after January 1, 1997, all clearinghouses will be required to be licensed by the State in order to do business as a health data clearinghouse. The Council shall recommend proposed legislation for mandatory licensure to the 1995 General Assembly, Regular Session 1996. Licensure shall require minimum standards applied by licensees to ensure security and integrity of data collected and disseminated.

(9) Develop a plan and proposed legislation for requiring use of electronic data interchange (EDI). The plan should be reported to the 1995 General Assembly, Regular Session 1996, and should provide that by January 1, 1997, all claims, encounters, remittances, eligibility verifications, and other health care related transactions shall be transmitted by electronic means by all health care providers, licensed insurers, managed care organizations, third party administrators, and other participants involved in the administrative processing of health care insurance and delivery transactions. The phased-in transition should be based on ANSI X.12 standards and should state specified data element requirements and appropriate security measures to protect the confidentiality of patient information.

"**§ 131G-1-3. North Carolina Health Data Policy Council; membership.**

(a) The North Carolina Health Data Policy Council shall consist of 17 voting members.

(b) The following appointments shall be made by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121:

(1) One representative of an employer of 200 or more employees in a business that is unrelated to a health care provider or third-party payer;

(2) One representative of a commercial insurance company providing health insurance in North Carolina;

(3) One nurse who provides raw data to the North Carolina Health Care Database or who is employed by a health care provider who provides raw data to the North Carolina Health Care Database; and

(4) One physician.

(c) The following appointments shall be made by the President Pro Tempore of the Senate in accordance with G.S. 120-121:

(1) One representative of an employer of less than 200 employees in a business that is unrelated to a health care provider or third-party payer;

(2) One representative of Blue Cross and Blue Shield of North Carolina;

(3) One health care provider that provides raw data to the North Carolina Health Care Database; and

(4) One hospital administrator.

(d) The following appointments shall be made by the Governor:

(1) One State employee who is not employed in an executive or managerial position and who is covered under the State Teachers' and Employees' Comprehensive Major Medical Plan or under a Health Maintenance Organization authorized to offer coverage to State employees;

(2) One representative of the commercial health care infomatics industry;

(3) One private citizen who is not affiliated with the health care provider or payer community, is not an employer, and who receives medical benefits;

(4) One home care provider;

(5) One representative of a Health Maintenance Organization or Preferred Provider Organization;

(6) One person with expertise in training health care providers;

(7) One practicing medical faculty member on rotation in the four State medical teaching hospitals;

(8) One person with expertise in health services research; and

(9) One rural health care provider.

The Insurance Commissioner, the Secretary of Human Resources, the Secretary of the Department of Environment, Health, and Natural Resources, and the Director of the Office of State Planning or their designees, shall be ex officio members of the Council without voting power. Any member of the Council shall be automatically removed from the Council upon certification by the Council to the appointing authority that the member no longer satisfies the requirements for appointment to the Council set forth in this section.

Vacancies on the Council shall be filled by the original appointing authority in accordance with the requirements of this section.

(c) The members of the Council shall serve terms of three years and may serve not more than two consecutive full three-year terms.

(d) The members of the Council shall receive necessary travel and subsistence expenses in accordance with G.S. 138-5.

(e) A majority of the voting members of the Council shall constitute a quorum.

(f) The members of the Council shall select a chair and vice-chair. Effective for terms to begin on or after July 1, 1997, no person may be elected chair or vice-chair unless the person has been a member of the Council for one year before the person's election. Effective July 1, 1997, the term of the chair and vice-chair shall be one year, and no person may be elected to the same office for more than two full consecutive terms.

(g) The Council shall meet at least once during each calendar quarter upon the call of the chair.

"**§ 131G-1-4. North Carolina Health Data Policy Council; powers and duties.**

(a) The Council shall issue annual reports on or before March 15 of each calendar year. Reports shall include recommendations and proposed legislation needed to further the purposes of this Act. Copies of the reports shall be submitted to the General Assembly, the Governor, and the North Carolina Health Planning Commission.

(b) The Council may hire professional and other staff needed to implement the requirements of this Article.

(c) The Council shall prepare and submit its annual budget directly to the Department of Human Resources.

(d) The Council may accept gifts, grants, donations, or contributions from any source. These funds shall be held in a separate account and used solely in furtherance of the purposes of this Article.

(e) The Council may establish committees to study issues related to the operation of the Council and to further the purposes of this Article.

(f) The Council shall adopt policies and guidelines to ensure that unneeded or irrelevant data will not be collected or disseminated, that information collected will be kept current and accurate, and that patient privacy shall be protected in accordance with State and federal law.

(g) The Council may adopt rules to implement this Article.

"ARTICLE 2.

"NORTH CAROLINA HEALTH CARE DATABASE.

"131G-2-1. Purpose.

The General Assembly finds that as a result of rising medical care costs and concerns expressed by medical care providers, medical consumers, third-party payers, and health care planners involved with planning for the provision of medical care, there is a continuing need to understand patterns and trends in the use and cost of these services. It is the intent and purpose of this Article to establish an information base to be used to improve the appropriate and efficient usage of medical care services, while at the same

time maintaining an acceptable quality of health care services in this State. This is to be accomplished by the compilation, coordination, analysis, and dissemination of a uniform set of health-related data. It is the intent of the General Assembly to require that the information necessary for a review and comparison of cost, utilization patterns, and quality of medical services be supplied to the North Carolina Health Care Database by all medical care providers and third-party payers both public and private. It is also the intent of the General Assembly that any duplication in the collection of medical care data shall be eliminated as recommended by the Health Data Policy Council and by the North Carolina Health Care Database. The information shall be compiled by a statewide data repository and made available in patient privacy protected form to interested persons, including medical care providers, payers, medical care consumers, and health care planners to improve the decision-making processes regarding access, identified needs, patterns of medical care, price and use of appropriate medical care services. The North Carolina Health Care Database shall take steps to assure that patient confidentiality is protected. However, the limited use of the social security numbers of patients as provided in G.S. 131G-2-3 and G.S. 131G-2-4 is vital to insuring the degree of accuracy of the information base contemplated by this Article and to achieve the purposes of the General Assembly in enacting this Act.

"**§ 131G-2-2. North Carolina Health Care Database created.**

(a) There is created in the Department of Insurance the North Carolina Health Care Database to receive health care data from providers and insurers, construct databases, analyze cost and utilization trends, and oversee dissemination of data to users and to further the purposes, findings, and declarations of the General Assembly as found in G.S. 131G-1-1. The Database may require that data be submitted to a data processor from all State agencies and State supported providers and from all medical care providers and third-party payers both public and private as in accordance with this Article; provided, however, that any data submitted by a medical provider to the Database shall not be required to be submitted to another State agency, commission, or board, except for Medicaid reimbursement data and reports otherwise required by State law or federal regulation.

(b) The Database shall survey the types of discharge and encounter specific data on medical services collected by the State and shall make recommendations for the elimination of duplication in the collection of that data. The Database shall develop plans for expanding the uniform database, which shall begin with data from in-patient hospital admissions, then shall include data at the earliest feasible time from hospital emergency rooms, hospital ambulatory surgery centers, freestanding ambulatory surgery centers, and other medical providers including, but not limited to, all licensed health care professionals or entities providing health care services as described in G.S. 131G-2-3. The initial mechanism for data collection will be the UB-92 claim form, or subsequent forms as adopted, for hospital inpatients.

(c) The Database shall have the authority to set fees with regard to the collection, compilation, and dissemination of data and to provide reimbursement to data providers in accordance with G.S. 58-3-171.

(d) The Database shall adopt standard coding systems to assure adequate data quality.

"**§ 131G-2-3. Powers and duties of the North Carolina Health Care Database.**

(a) The Database shall contract with an organization that shall act as a data processor. The data processor shall, pursuant to rules and policies adopted by the Commissioner of Insurance, collect the data from the hospitals, third-party carriers, State agencies, and others as described in subdivision (b)(1) of this section; build and maintain the database; analyze the information; and prepare reports. In addition, the Database shall facilitate data exchange among private networks, become a portal for public access to needed health data, and shall analyze health data.

(b) The Commissioner of Insurance may adopt rules governing the acquisition, compilation, and dissemination of all data collected pursuant to this Article. The rules shall provide, at a minimum that:

(1) The Commissioner of Insurance shall require all third-party payers, including licensed insurers, medical and hospital service corporations, health maintenance organizations, and self-funded employee health plans to provide to the Database the claims data, as required by this Article. The data shall be provided in the most useful form possible to the data processor, which may include copies of the UB-92 to report hospital inpatient claims information, datatape, or other electronic media.

(2) These data shall include the following: patient's age, sex, zip code, third-party coverage, principal and other diagnoses, date of admission, procedure and discharge date, principal and other procedures, total charges and components of those charges, attending physician identification number, and hospital identification number. In accordance with the findings of the General Assembly set forth in this Act, data provided to the Database may include the patient's social security number but the handling and disclosure of such number shall be in accordance with this Article.

(3) The Database shall ensure that adequate measures have been taken to provide system security for all data and information acquired under this Article.

(4) The data shall be collected in the most efficient and cost-effective manner and the providers of the data shall be reimbursed for the reasonable cost incurred in providing the actual data to the Database.

(5) The Database shall develop procedures to assure the confidentiality of patient records. Patient names, addresses, and other patient identifying information shall be omitted from the database. For purposes of this section, the social security numbers of patients shall not be considered to be patient identifying information, although the further dissemination of such numbers shall be governed by the provisions of this Article.

(6) A data provider may obtain data it has submitted as well as other aggregate data, but it may not access data submitted by another provider and which is limited only to that provider. In no event may a data provider obtain data regarding the social security number of a patient except in instances when that data was originally submitted by the requesting provider. Prior to the release or dissemination of any data, in any form, the Database shall permit providers an opportunity to verify the accuracy of any information pertaining to the provider.

(7) The Database shall charge users for the cost of data preparation for information that is beyond the routine data disseminated by the Database.

(8) Time limits shall be set for the submission and review of data by data providers and penalties shall be established for failure to submit and review the data within the established time.

(9) The Database shall collect encounter data from health care transaction clearinghouses.

(10) The Database shall establish an identifier system for the unique identification of patients, providers, employers, third-party administrators, and utilization review organizations. For patients, the identifier shall be based on the patient's social security number. For others, the identifier number shall be based on uniform application of nationally recognized standards for unique health-related identifier numbers.

(11) The Database shall develop standards with respect to the following:

a. Licensure of health care transactions and data clearinghouses,
b. Electronic Data Interchange (EDI),
c. Security and confidentiality of data,
d. Unique identifier numbers,
e. Coding conventions,
f. Data element standardization, and
g. Cost-effective means for gathering data on all types of health care encounters.

(12) Effective October 1, 1996, all health plan administrators who issue electronic patient identification cards shall ensure that the cards have a magnetic stripe on the reverse side, which when scanned, shall provide the following information:

a. Patient name, address, social security number, and next of kin,
b. Payer information, benefit coverage, precertification requirements, and
c. Name of third-party administrators and relevant phone numbers.

Magnet coding shall be in accordance with existing ANSI standards.

(c) In addition to the duties set out in this section, the Database shall expand current data collection and analysis to include data from all ambulatory care sites. The expanded data collection shall include:

(1) Patient encounters relating to the delivery of primary care through physician offices, outpatient clinics, and public health clinics, and

(2) A minimum data set regarding the delivery of health care services via home health agencies.

Over time and as funds permit, the Database shall expand this capability further to eventually collect data on all ambulatory medical treatments and health services provided within North Carolina, including those associated with indemnity, managed care, federal, self-funded, and State-funded programs.

(d) Any person who submits data as required by this Article shall be immune from liability in any civil action. This immunity is in addition to any other immunity to which the person is otherwise entitled.

(e) Data collected by and furnished to the Database pursuant to this Article shall not be shared among other State agencies unless the information is approved by the Database as a public record pursuant to G.S. 131G-2-4. Notwithstanding the provisions of G.S. 131G-2-4, the Database shall, as soon as practicable after a request by the State Health Director, and where not otherwise prohibited by federal law, make available to the State Health Director specific individual records, including patient and provider identifiers, in furtherance of the mandate in Chapter 130A of the General Statutes to protect and promote the public health. Records obtained in this manner shall be confidential, shall not be public records, and shall not be made available by the State Health Director notwithstanding G.S. 130A-374(a)(2).

(f) The Database may not use the data collected for a purpose other than as authorized by this Article.

(g) The Database shall ensure that no collection of unneeded or irrelevant data will be allowed and that information collected will be kept current and accurate.

"**§ 131G-2-4. North Carolina Health Care Database not public records.**

The individual forms, computer tapes, or other forms of data collected by and furnished to the Database or data processor shall not be public records under Chapter 132 of the General Statutes and shall not be subject to public inspection. After approval by the Database, the compilations prepared for release or dissemination from the data collected, except for a report prepared for an individual data provider containing information concerning only its transactions, shall be public records. The confidentiality of patient identifying information is to be protected and the pertinent statutes, rules, and regulations of the State of North Carolina and of the federal government relative to patient confidentiality shall apply. For purposes of this section, patient identifying information means the name, address, social security number or similar information by which the identity of the patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a patient identifying number assigned by a program. In any event, the patient identifying information (as defined in this section) obtained shall not be further disclosed,

and may not be used in connection with any legal, administrative, supervisory, or other action whatsoever with respect to such patient. The Database shall hold such information in confidence, is prohibited from taking any administrative, investigative, or other action with respect to any individual patient on the basis of such information, and is prohibited from identifying, directly or indirectly, any individual patient in any report of scientific research or long-term evaluation, or otherwise disclosing patient identities in any manner. Further, patient identifying information submitted to the Database which would directly or indirectly identify any patient may not be disclosed by the Database either voluntarily or in response to any legal process whether federal or State unless authorized by an appropriate court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

"**§ 131G-2-5. Data collection on special populations; special populations defined.**

(a) The Database shall ensure that public and private data collection efforts and community health assessments are collected and maintained in a format such that the health status of special populations in North Carolina may be ascertained.

(b) For purposes of data collection and community health assessment, a person is determined to be part of a 'special population' if any one or more of the following applies to the person:

(1) The person is a member of a racial or ethnic minority group;

(2) The person is or has been employed as a migrant worker or seasonal farm worker;

(3) The person is an undocumented alien;

(4) The person is disabled; for purposes of this subdivision, a person is disabled if the person has a physical or mental impairment that substantially limits one or more major life activities, or if the person has a record of such impairment, or if the person is regarded as having such an impairment;

(5) The person's annual gross income is at or below two hundred percent (200%) of the federal poverty level;

(7) The person is uninsured; or

(8) The person resides in a rural or urban health professional shortage area as defined by the Office of Rural Health and Resource Development.

"**§ 131G-2-6. Patient access to health data collected; penalties for unauthorized release of patient information.**

(a) The Commissioner of Insurance, after consultation with the North Carolina Health Care Database and the State Center for Health and Environmental Statistics, shall adopt rules for assuring privacy, accuracy, and control of patient information, and for enabling patients to have access, under limited circumstances, to all health data collected

and stored about the requesting patient, whether collected and stored by public or private entity.

(b) A person may request in writing of any public or private entity collecting health data about the person to review health data records kept on that person by the entity in order that the person may be informed about the data that is being collected about the person's health. All health data records kept on the requesting person shall be made available by the collecting entity to the person for purposes of verifying the accuracy of the data, for submitting corrective information to be annotated in the record by the entity having possession of the data, and to specify in writing other parties to whom the person authorizes disclosure of information in the person's health data records. A person reviewing health data information under this subsection may not change any of the information contained in the record. However, if the person believes the data in the record is erroneous or incomplete, the person shall provide the correct or complete information to the collection entity and may request the collection entity in writing to annotate the record to that effect. Upon receipt of the written request and corrected or additional information, the collection entity shall either correct the record or annotate it as requested.

(c) Any person who knowingly or willfully releases or knowingly or willfully permits the unauthorized release of information from a health data collection record and who is not authorized under any State or federal law to release the information, shall be guilty of a Class 3 misdemeanor and upon conviction shall be fined in the discretion of the court but not in excess of five hundred dollars ($500.00).

"ARTICLE 3.

"STATE HEALTH DATA MANAGEMENT CONSORTIUM.

"**§ 131G-3-1. State Health Data Management Consortium established.**

(a) There is established the State Health Data Management Consortium whose primary purpose shall be to provide a forum for more effective communication among representatives of State agencies that are involved in health related data collection, analysis, and dissemination.

(b) The Consortium shall be comprised of representatives from the following State agencies:

(1) State Center for Health and Environmental Statistics;
(2) North Carolina Health Care Database;
(3) Cecil G. Sheps Center;
(4) DHR Facility Services;
(5) DHR Mental Health Statistics;
(6) State Data Center of the Office of State Planning; and
(7) Other State agencies that routinely coordinate data collection and analysis activities.

(c) The Consortium shall be convened by the North Carolina Health Data Policy Council and shall meet as necessary to carry out the purposes of this Article. Initial duties of the Consortium shall include:

(1) Develop common data element definition, interpretation, and utilization;

(2) Improve standardization of technology application;
(3) Identify and eliminate duplicative data collection and analysis efforts;
(4) Exchange ideas and share common approaches to data collection, analysis, and telecommunications; and
(5) In consultation with the appropriate occupational licensing boards and health facility licensing authorities, review and assess the existing data collection practices relating to all licensed health professionals and institutions.

(d) The Consortium shall keep the Health Data Policy Council and the North Carolina Health Planning Commission apprised of its progress and recommendations for carrying out the purposes of its duties under this Article."

Sec. 4.3. (a) Effective October 1, 1995, all persons serving on the North Carolina Medical Database Commission shall be deemed appointed to the North Carolina Health Data Policy Council for the remainder of each person's unexpired term on the North Carolina Medical Database Commission. Upon expiration of the term of a Council member appointed to the Council pursuant to this section, for purposes of reappointment to the Council and for purposes of service as chair or vice-chair of the Council, the provisions of G.S. 131G-1-3 shall govern.

Sec. 4.4. Effective October 1, 1995, the management functions, personnel, database, and all records and files of the North Carolina Medical Database Commission are transferred to the Department of Insurance by a Type II transfer as provided under G.S. 143A-6.

Sec. 4.5. Effective October 1, 1995, Chapter 93B of the General Statutes is amended by adding the following new section to read:

"**§ 93B-12. Information from licensing boards having authority over health care providers.**

(a) Every occupational licensing board having authority to license an individual to provide health care in this State shall modify procedures for license renewal to include the collection of information specified in this section. The purpose of this requirement is to assist the State in tracking the availability of health care providers to determine which areas in the State suffer from inequitable access to specific types of health services, and to anticipate future health care shortages which might adversely affect the citizens of this State. Occupational licensing boards, in consultation with the North Carolina Health Data Policy Council, shall collect, report, and update the following information:

(1) Area of medical specialty practice;
(2) Address of all locations where the licensee practices;
(3) Other information the occupational licensing board in consultation with the North Carolina Health Data Policy Council deems relevant to assisting the State achieving the purpose set out in this section.

(b) Every occupational licensing board required to collect information pursuant to subsection (a) of this section shall report and update the information on an annual basis to the North Carolina Health Care Database and the North Carolina Area Health Education Centers Program. If either or both of these agencies is abolished, then the report shall be

submitted to the North Carolina Health Data Policy Council. Information provided by the occupational licensing board pursuant to this subsection may be provided in such form as to omit the identity of the health care licensee."

Sec. 4.6. Effective October 1, 1995, the North Carolina Medical Care Commission shall adopt rules to ensure that the following information pertaining to every hospital and health care facility under its licensing authority shall be submitted to the North Carolina Health Care Database and shall be updated on an annual basis:

(1) The name and address of every facility licensed to provide health care in this State;

(2) The types of health care services provided at each facility;

(3) The areas of practice of every licensed health care professional providing services at each facility.

The purpose of the information required under this section is to assist the State in tracking the availability of health care providers and facilities to determine which areas in the State suffer from inequitable access to specific types of health services, and to anticipate future health care facility shortages which might adversely affect the citizens of this State.

PART V – PRIMARY CARE INITIATIVES

Sec. 5.1. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 31.

"PRIMARY CARE PRACTICE.

"§ 90-460. Purpose.

The purpose of this Article is to provide a definition of the terms 'primary care' and 'primary care provider' that may be uniformly applied by health care institutions, occupational licensing agencies, health-related professional associations, and health care provider associations. The definition provides a framework for use in health care reform efforts to achieve the following goals:

(1) Reorientation of medical and health professional education curricula to produce physicians, physician assistants, certified nurse midwives, and nurse practitioners that provide primary care as it is defined in this section;

(2) Development and implementation by professional licensing boards of a new credentialing category called 'primary health care' based on the definition of that term in G.S. 90-461(a);

(3) Restrict reimbursement from both public and private sources for primary care services to those providers who meet the definition in G.S. 90-461.

"§ 90-461. 'Primary care' and 'primary care provider' defined.

(a) The term 'primary care' or 'primary health care' means the health services and related activities provided by a health care professional to an individual with whom the provider has an ongoing patient-provider relationship and with whom the provider shares

a mutual responsibility for protecting, improving, and maintaining the individual's health, for promoting the individual's wellness, and for treating the individual's illnesses. All of the following are necessary elements of primary care:

(1) Availability. Primary care is available as follows:
  a. Nonemergency appointments with the primary care provider are scheduled within a reasonable time frame;
  b. Directly from the provider on a round-the-clock, everyday basis, or, when not available directly from the provider, the provider ensures that care is readily available from an alternate provider, as follows:
    1. Through arrangement with other specified providers accessible to the patient, and
    2. Patients are informed of the arrangements and are routinely apprised of how to obtain the necessary care from the alternate provider, and
    3. The arrangement includes communication between the provider and the alternate provider on all contacts between the alternate provider and the primary care provider's patient.
  c. Providers are willing to assist patients in overcoming financial, organizational, and other barriers to primary care that may exist.

(2) Continual provider-patient relationship. Primary care is provided through a relationship between the primary care provider and patient that:
  a. Is intended by both parties to be ongoing in nature,
  b. Both parties expect will endure across time, health status, and sites of care,
  c. Is evidenced by mutual trust and communication,
  d. Includes knowledge and understanding of the patient, the patient's family, and the sociocultural context of the patient's life environment, and
  e. Includes a formal process of preventive care and treatment of existing illness and extends to subsequent treatment and advice.

(3) Comprehensive services. Primary care is provided for the broad and complete scope of health-related needs of the patient, and includes incorporation of input from specialists, consultants, and other resources, when appropriate.

(4) Integration of all care provided. The primary care provider is continually and effectively involved in all health care provided to the provider's patient, including, but not limited to:
  a. Participation in the selection of members of a collaborative health care team providing services to the patient;

b. Identifying appropriate providers to deliver services beyond the scope of the primary care provider's knowledge, skill, expertise, and time constraints;
c. Making all pertinent information known by the provider available to other providers involved in the patient's care;
d. Obtaining all relevant information, findings, and advice from other providers pertaining to the care and treatment of the primary care provider's patient;
e. Effective communication with the patient as to information obtained from other providers, and assisting the patient in making informed decisions about the patient's care; and
f. Ensuring that the patient's medical records accurately reflect all information obtained by the primary care provider pertinent to ensuring continuous effective primary care to the patient.

(5) Care provided is technically sound and appropriately adapted. Primary care is technically sound when it:
a. Meets standards of care that are widely accepted by the health care profession,
b. Imposes a duty upon the primary care provider to possess and act upon the scientific and social knowledge and technical expertise required of the community of primary care professionals, and
c. Imposes a duty on the primary care provider to seek collegial support and counsel where the nature or complexity of the health care matter at hand is beyond the scope of the primary care provider's knowledge and skills.

Primary care is appropriately adapted when it recognizes and reflects the patient's:
d. Health status,
e. Health and health care goals and expectations,
f. Personal and medical history, family, work, and sociocultural environment, and preferences and ideals with respect to health care.

(b) The term 'primary care provider' means an individual who provides primary care to patients in accordance with subsection (a) of this section and who is:
(1) A physician licensed by the Board of Medical Examiners, or
(2) Approved by the Board of Medical Examiners to practice as a physician assistant, or
(3) Authorized by the Board of Medical Examiners and the Board of Nursing to practice as a nurse practitioner, or
(4) Approved by the Board of Medical Examiners and the Board of Nursing to practice midwifery, or
(5) A licensed or certified health care provider."

Sec. 5.2. Effective January 1, 2000, G.S. 90-461(b) reads as rewritten:

"(b) The term 'primary care provider' means an individual who provides primary care to patients in accordance with subsection (a) of this section and who is:

(1) A physician licensed by the Board of Medical ~~Examiners, or~~ Examiners and certified by the Board to provide primary care in accordance with subsection (a) of this section, or

(2) Approved by the Board of Medical Examiners to practice as a physician ~~assistant, or~~ assistant and certified by the Board to provide primary care in accordance with subsection (a) of this section, or

(3) Authorized by the Board of Medical Examiners and the Board of Nursing to practice as a nurse ~~practitioner, or~~ practitioner and certified by both Boards to provide primary care in accordance with subsection (a) of this section, or

(4) Approved by the Board of Medical Examiners and the Board of Nursing to practice ~~midwifery, or~~ midwifery and certified by both Boards to provide primary care in accordance with subsection (a) of this section, or

(5) A licensed or certified health care provider."

Sec. 5.3. (a) The Board of Medical Examiners and the North Carolina Board of Nursing shall jointly convene a task force to propose actions necessary by each Board and by the General Assembly in order to authorize and implement collaborative practice between and among primary care health care physicians and mid-level providers. The task force shall include representatives from the following:

(1) The North Carolina Chapter of the American College of Nurse Midwives,

(2) The North Carolina Nurses Association,

(3) The North Carolina Academy of Physician Assistants,

(4) The North Carolina Academy of Family Physicians,

(5) The North Carolina Academy of Pediatrics,

(6) The North Carolina Society of Internal Medicine,

(7) The North Carolina Medical Society, and

(8) Other professional associations necessary to carry out the purposes of this section.

(b) The task force proposal shall include a definition of "collaborative practice" and shall be designed to permit professional practice incorporation across professional boundaries to include collaborative practice between physicians and health care providers licensed or certified under the Medical Practice Act. In developing its proposal, the task force shall consider professional practice rules, state licensing standards, public and private reimbursement policies, and medical and health professional education programs and shall propose ways they can be reoriented or otherwise changed to encourage and facilitate the development of collaborative practice.

(c) The task force shall report its findings and recommendations to The Board of Medical Examiners and the North Carolina Board of Nursing for their adoption. The Board of Medical Examiners and the North Carolina Board of Nursing shall jointly

submit a report to the 1995 General Assembly, upon convening of the Regular Session 1996, on the findings and recommendations of the task force, including proposed statutory changes and other action necessary by the General Assembly to make lawful and encourage the development of collaborative practice incorporation among the providers under their licensing authority.

Sec. 5.4. G.S. 143-613 reads as rewritten:

"**§ 143-613. Medical education; primary care ~~physicians.~~ providers.**

(a) In recognition of North Carolina's need for primary care physicians, Bowman Gray School of Medicine and Duke University School of Medicine shall each prepare a plan with the goal of encouraging North Carolina residents to enter the primary care disciplines of general internal medicine, general pediatrics, family medicine, obstetrics/gynecology, and combined medicine/pediatrics and to strive to have at least fifty percent (50%) of North Carolina residents graduating from each school entering these disciplines. These schools of medicine shall present their plans to the Board of Governors of The University of North Carolina by April 15, ~~1994.~~ 1996, and shall update and present their plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, ~~1994,~~ 1996, and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

(a1) In recognition of North Carolina's need for primary care mid-level providers, all privately funded health professional schools that provide training for licensure or certification of physician assistants, nurse practitioners, and nurse midwives shall each prepare a plan with the goal of encouraging North Carolina residents to enter primary care training programs related to the practice of general internal medicine, general pediatrics, family medicine, obstetrics/gynecology, and combined medicine/pediatrics. These health professional schools shall present their plans to the Board of Governors of The University of North Carolina by April 15, 1996, and shall update and present their plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1996, on the status of these efforts to strengthen primary health care in North Carolina. As used in this section, the term 'mid-level provider' means a physician assistant, nurse practitioner, or certified nurse midwife.

(b) The Board of Governors of The University of North Carolina shall set goals for the Schools of Medicine at the University of North Carolina at Chapel Hill and the School of Medicine at East Carolina University for increasing the percentage of graduates who enter residencies and careers in primary care. A minimum goal should be at least sixty percent (60%) of graduates entering primary care disciplines. Each school shall submit a plan with strategies to reach these goals of increasing the number of graduates entering primary care disciplines to the Board by April 15, ~~1994.~~ 1996, and shall update and present the plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, ~~1994,~~ 1996, and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

Primary care shall include the disciplines of family medicine, general pediatric medicine, general internal medicine, internal medicine/pediatrics, and obstetrics/gynecology.

(b1) The Board of Governors of The University of North Carolina shall set goals for publicly funded health professional schools that offer training programs for licensure or certification of physician assistants, nurse practitioners, and nurse midwives for increasing the percentage of the graduates of those programs who enter clinical programs and careers in primary care. Each health professional school shall submit a plan with strategies for increasing the percentage to the Board by April 15, 1996, and shall update and present the plan every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1996, and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

(c) The Board of Governors of The University of North Carolina shall further initiate whatever changes are necessary on admissions, advising, curriculum, and other policies for State-operated medical schools and health professional schools to ensure that larger proportions of ~~medical~~ students seek residencies and clinical training in primary care disciplines. The Board shall work with the Area Health Education Centers and other entities, adopting whatever policies it considers necessary to ensure that residency and clinical training programs have sufficient ~~medical~~ residency and clinical positions for ~~medical school~~ graduates in these primary care specialties. As used in this subsection, health professional schools are those schools or institutions that offer training for licensure or certification of physician assistants, nurse practitioners, and nurse midwives.

(d) The progress of the private and public medical schools and health professional schools towards increasing the number and proportion of graduates entering primary care shall be monitored annually by the Board of Governors of The University of North Carolina. Monitoring data shall include (i) the entry of State-supported ~~medical~~ graduates into primary care ~~residencies,~~ residencies and clinical training programs, and (ii) the specialty practices by a physician and each mid-level provider as of a date five years after graduation. The Board of Governors shall certify data on graduates, their ~~residencies,~~ residencies and clinical training programs, and subsequent careers by October 1 of each calendar year, beginning in October of 1995, to the Fiscal Research Division of the Legislative Services Office and to the Joint Legislative Education Oversight Committee.

(e) The information provided in subsection (d) of this section shall be made available to the Appropriations Committees of the General Assembly for their use in future funding decisions on medical and health professional education."

Sec. 5.5. Effective with each school's 1997-98 fiscal year, Bowman Gray School of Medicine, Duke University School of Medicine, each privately and publicly funded health professional school, and the Board of Governors of The University of North Carolina for the Schools of Medicine at the University of North Carolina at Chapel Hill, and the School of Medicine at East Carolina University, shall reallocate their publicly funded budget priorities and expenditures for the 1997-98 fiscal year and beyond

to focus on educational programs that produce primary care providers. The Schools of Medicine and the health professional schools covered under this section that receive State funds shall expand the number of primary care residencies and clinical training programs available and shall develop an equitable form of State-funded payment for assisting the practice sites that participate in the teaching of students training to be primary care providers. As used in this section, the term "primary care provider" includes physicians, physician assistants, nurse practitioners, and certified nurse midwives. As used in this section, the term "health professional school" includes those schools that provide training for licensure or certification of physician assistants, nurse practitioners, and nurse midwives. As used in this section, the term "primary care" includes the disciplines of family medicine, general pediatric medicine, general internal medicine, internal medicine/pediatrics, and obstetrics/gynecology.

Sec. 5.6. Effective January 1, 2000, G.S. 143-613 reads as rewritten:

"**§ 143-613. Medical education; primary care providers.**

(a) In recognition of North Carolina's need for primary care physicians, Bowman Gray School of Medicine and Duke University School of Medicine shall each prepare a plan with the goal of encouraging North Carolina residents to enter ~~the primary care~~ academic disciplines related to primary care as that term is defined under G.S. 90-461 ~~of general internal medicine, general pediatrics, family medicine, obstetrics/gynecology, and combined medicine/pediatrics~~ and to strive to have at least fifty percent (50%) of North Carolina residents graduating from each school entering these disciplines. These schools of medicine shall present their plans to the Board of Governors of The University of North Carolina by April 15, 1996 and shall update and present their plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1996 and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

(a1) In recognition of North Carolina's need for primary care mid-level providers, all privately funded health professional schools that provide training for licensure or certification of physician assistants, nurse practitioners, and nurse midwives shall each prepare a plan with the goal of encouraging North Carolina residents to enter primary care training programs related to the practice of primary care as that term is defined under G.S. 90-461. ~~general internal medicine, general pediatrics, family medicine, obstetrics/gynecology, and combined medicine/pediatrics.~~ These health professional schools shall present their plans to the Board of Governors of The University of North Carolina by April 15, 1996, and shall update and present their plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1996, on the status of these efforts to strengthen primary health care in North Carolina. As used in this section, the term 'mid level provider' means a physician assistant, nurse practitioner, or certified nurse midwife.

(b) The Board of Governors of The University of North Carolina shall set goals for the Schools of Medicine at the University of North Carolina at Chapel Hill and the School of Medicine at East Carolina University for increasing the percentage of graduates who enter residencies and careers in primary ~~care.~~ care as that term is defined under G.S.

90-461. A minimum goal should be at least sixty percent (60%) of graduates entering primary care disciplines. Each school shall submit a plan with strategies to reach these goals of increasing the number of graduates entering primary care disciplines to the Board by April 15, 1996 and shall update and present the plans every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Committee by May 15, 1996 and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

Primary care is that type of care defined under Article 31 of Chapter 90 of the General Statutes. ~~shall include the disciplines of family medicine, general pediatric medicine, general internal medicine, internal medicine/pediatrics, and obstetrics/gynecology.~~

(b1) The Board of Governors of The University of North Carolina shall set goals for publicly funded health professional schools that offer training programs for licensure or certification of physician assistants, nurse practitioners, and nurse midwives for increasing the percentage of the graduates of those programs who enter clinical programs and careers in primary ~~care.~~ care as defined under G.S. 90-461. Each health professional school shall submit a plan with strategies for increasing the percentage to the Board by April 15, 1996 and shall update and present the plan every two years thereafter. The Board of Governors shall report to the Joint Legislative Education Oversight Commission by May 15, 1996 and every two years thereafter on the status of these efforts to strengthen primary health care in North Carolina.

(c) The Board of Governors of The University of North Carolina shall further initiate whatever changes are necessary on admissions, advising, curriculum, and other policies for State-operated medical schools and health professional schools to ensure that larger proportions of students seek residencies and clinical training in primary care disciplines. The Board shall work with the Area Health Education Centers and other entities, adopting whatever policies it considers necessary to ensure that residency and clinical training programs have sufficient residency and clinical positions for graduates in these primary care specialties. As used in this subsection, health professional schools are those schools or institutions that offer training for licensure or certification of physician assistants, nurse practitioners, and nurse midwives.

(d) The progress of the private and public medical schools and health professional schools towards increasing the number and proportion of graduates entering primary care shall be monitored annually by the Board of Governors of The University of North Carolina. Monitoring data shall include (i) the entry of State-supported graduates into primary care residencies and clinical training programs, and (ii) the specialty practices by a physician and each mid level provider as of a date five years after graduation. The Board of Governors shall certify data on graduates, their residencies and clinical training programs, and subsequent careers by October 1 of each calendar year, beginning in October of 1995, to the Fiscal Research Division of the Legislative Services Office and to the Joint Legislative Education Oversight Committee.

(e) The information provided in subsection (d) of this section shall be made available to the Appropriations Committees of the General Assembly for their use in future funding decisions on medical and health professional education."

PART VI – NORTH CAROLINA HEALTH PLANNING COMMISSION REORGANIZATION

Sec. 6.1. G.S. 143-611 reads as rewritten:

"**§ 143-611. Commission established; members; terms of office; quorum; compensation.**

(a) Establishment. – There is established the North Carolina Health Planning Commission with the powers and duties specified in this Article. The Commission shall be located within the Office of the Secretary, Department of Human Resources, for organizational, budgetary, and administrative purposes.

(b) Membership and Terms. – The Commission shall consist of 16 members, as follows:

(1) The ~~Governor;~~ Governor or the Governor's designee;

(2) The Lieutenant Governor;

(3) The Speaker of the House of Representatives;

(4) The President Pro Tempore of the Senate;

(5) ~~Five~~ Four members appointed by the Speaker of the House of Representatives, at least two of whom are members of the House of Representatives at the time of appointment; ~~appointed by the Speaker of the House of Representatives;~~

(6) ~~Five~~ Four members appointed by the President Pro Tempore of the Senate, at least two of whom are members of the Senate at the time of the appointment; and ~~appointed by the President Pro Tempore of the Senate; and~~

~~(7) The following nonvoting members, ex officio:~~

~~a. The Secretary of the Department of Environment, Health, and Natural Resources; and~~

~~b. The Secretary of the Department of Human Resources.~~

(7a) Four members appointed by the Governor, two of whom shall be members of the majority party in this State and two of whom shall be members of the minority party in this State.

Members shall serve two-year terms. Vacancies in membership shall be filled by the appointing authority in accordance with this section.

(c) Compensation. – The Commission members shall receive no salary as a result of serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, 138-5, and 138-6, as applicable.

(d) Meetings. – The Governor shall convene the Commission. Meetings shall be held as often as necessary, but not less than six times a year.

(e) Quorum. – A majority of the voting members of the Commission shall constitute a quorum for the transaction of business. The affirmative vote of a majority of the members present at meetings of the Commission shall be necessary for action to be taken by the Commission."

Sec. 6.2. G.S. 143-612 reads as rewritten:

"**§ 143-612. Powers and duties of the Commission.**

(a) Administrative Powers. – The Commission shall have the following administrative powers:

(1) To appoint a director, who shall be exempt from the State Personnel Act, and to employ other staff as it deems necessary, subject to the State Personnel Act, and to fix their compensation;

(2) To enter into contracts to carry out the purposes of this Article;

(3) To conduct investigations and inquiries and compel the submission of information and records the Commission deems necessary; and

(4) To accept grants, contributions, devises, bequests, and gifts for the purpose of providing financial support to the Commission. Such funds shall be retained by the Commission.

(b) Plan Development. – The Commission may develop a Plan for submission to the General Assembly. If the Commission develops a Plan in accordance with G.S. ~~58-68-23,~~ 58-68A-10, the Plan may incorporate the following:

~~(1) Annual review of the benefits package;~~

~~(2) Annual budget targets;~~

(3) Cost-containment measures to meet established annual budget targets;

~~(4) Independent actuarial cost estimates for the recommended benefit package;~~

(5) The amount of appropriations needed to finance the Plan;

(6) The methodology to be used in making risk-adjusted payments to the community health plans;

(7) The standards for eligibility for the Plan in addition to those contained in G.S. ~~58-68-22(3)~~ 58-68A-5(3) and G.S. 143-610(3);

(8) Accessibility to health care in rural and medically underserved areas through the enhancement of provider payments, requiring community health plans to provide services throughout their area, or by any other reasonable means;

(9) Supplemental health benefits for all eligible residents including employees of business entities; and

(10) The economic impacts of implementing the Plan, including overall costs to the State economy, costs to the State's business economy, costs to the State, impact on future State economic development, immediate effects on the job market in the State, and a 10-year projection of these items if the Plan is not implemented.

(c) Plan Study. – The Commission shall also study the following issues and may recommend to the General Assembly actions to address these issues:

(1) The steps necessary to include the populations served by Medicaid, including a statement of any necessary federal waivers;

(2) The steps necessary to obtain an exemption from the federal Employee Retirement and Income Security Act (ERISA);

(3) Examine the roles of other existing publicly financed systems of health coverage such as Medicare, federal employee health benefits, health benefits for armed services members, the Veterans Administration, the CHAMPUS program (10 U.S.C. § 1071 et seq.), and any other health benefits currently mandated by State or federal law or funded by State agencies;

(4) Whether existing retirement health benefits may be included in the Plan;

(5) The mechanisms for ensuring that the Plan will provide appropriate access to quality medical services for all eligible residents;

(6) The means by which the Plan will ensure that the needs of special populations of eligible residents such as low-income persons, people living in rural and underserved areas, and people with disabilities and chronic or unusual medical needs will be met;

(7) The role of the existing county health care system in the Plan;

(8) Proposals for consolidation of the health care components of workers' compensation and automobile insurance with the health coverage provided under the Plan to avoid duplication of coverage;

(9) The appropriate means of financing medical education and medical research;

(10) The appropriate method of collecting data for both quality assurance and cost containment, and in guiding the proliferation of new medical technologies;

(11) The means by which North Carolina's need for long-term care services can best be met, including an examination of the appropriateness and availability of home and community-based services;

(12) Whether medical malpractice tort reforms are needed, and, if so, the tort reforms needed;

~~(13) The development of medical practice parameters;~~

(14) The need for rate-setting in areas where sufficient competition does not exist;

(15) The need for the collection of data prior to implementation of the Plan and develop, if necessary, recommendations for the collection of such data;

(16) The impact of the Plan on small businesses and methods to alleviate undue financial burdens on small businesses, including, but not limited to, a specified monthly level of payroll upon which no assessment is made;

(17) The impact of the Plan on continued group health insurance for large groups;

(18) The use of licensed insurance agents and producers in the enrollment, education, and provision of service to eligible residents;

(19) The need for and methods to accomplish global budgeting;

(20) Methods to ensure adequate primary care for all eligible residents, and appropriate compensation for primary care services to achieve that end;
(21) Methods to increase the number of mobile health care units that provide services to communities that are underserved with respect to health care;
(22) The impact on health care cost and efficiency of rule changes made by State and local government agencies pertaining to health care services. The study shall include the impact of the frequency of such rule changes;
(23) The relationship between the Plan, regional health plan purchasing cooperatives, community health districts, a Department of Health, the Commission, and the Health Care Purchasing Alliances established under G.S. 143-627;
(24) The establishment of a health care trust fund in the State Treasurer's Office to serve as a depository for the following:
a. All revenues collected from taxes and other sources enacted for the purpose of funding the Plan;
b. All federal payments received as a result of any waiver of requirements granted by the United States Secretary of Health and Human Services under health care programs established under Title XIX of the Social Security Act, as amended; and
c. All moneys appropriated by the North Carolina General Assembly for carrying out the purposes of the Plan.
(25) Identification of need for additional benefits and population-based services to be offered in the community, based on the established priorities for improving community health status in the community;
(26) Mechanisms to provide for the continuing education and training of health care personnel and community health district boards; and
(27) Review of community health districts' reports and establishment of priorities for programs and financing to address community health district needs.

(c1) Other duties: In addition to other duties established under this Article, the Commission shall do the following:

(1) Study ways to maximize employer-based coverage;
(2) Study and report on trends in the numbers of uninsured and underinsured persons and barriers to access by these persons;
(3) Monitor efforts to increase the purchasing power of government health program;
(4) Study ways to maintain emergency medical services when hospital beds are reconfigured;
(5) Establish target health expenditures for both the public and private sectors for the 1995-96 fiscal year and for five years beyond. These targets shall be used to determine how closely the expenditures relate to the rate of real economic growth, and to determine the cumulative effect

of the State's and private sector's various cost containment measures. The Commission shall develop cost assessments for the following:

a. Total expenditures,

b. Public expenditures (State, local, federal), including Medicaid and State Health Plan benefits,

c. Private expenditures, including amounts for traditional insurance, HMOs, individual out-of-pocket and uncompensated care, and

d. Types of service, including primary, secondary, or tertiary care, physician or hospital care.

These cost assessment categories, as well as others deemed appropriate by the responsible agency, should be cross-cut by both public and private source of payment and type of service provider.

In evaluating the data, the Commission shall consider the principle that expenditures in each category should not increase more than the rate of real economic growth. The amounts for each category shall be updated at least every five years and shall be used to evaluate whether expenditures are being managed to determine the sectors of the health care system that are growing the fastest, and to educate the public and government leaders about the real cost of delivering health care to North Carolinians.

(6) Analyze the impact of changes enacted to the Certificate of Need laws;

(7) Review current conflict-of-interest laws;

(8) Assess the impact of locum tenens programs;

(9) Monitor and assess the quality of care provided in the State;

(10) Review proposals on collaborative practice;

(11) Study effectiveness of different types of preventive health services;

(12) Develop other ways to expand coverage to uninsured persons;

(13) Monitor the number of persons who lack access to primary care providers.

(d) Notwithstanding any other provision in this Article or Article 68A of Chapter 58 of the General Statutes, the Commission may develop its own health care proposals or plans or make any other recommendations to the General Assembly.

(e) The Commission shall appoint such advisory, technical, and professional panels as it deems necessary to advise it on the performance and administration of its functions. Each panel shall consist of experts drawn from the health professions, health educational institutions, providers of services, insurers, and other sources, including consumers. ~~At least three panels shall be established to advise, consult with, and make recommendations to the Commission on the development, maintenance, funding, evaluation, and priorities of community health services.~~"

Sec. 6.3. The Commission shall include in its reports to the General Assembly proposed legislation needed to implement recommendations of the Commission.

Sec. 6.4. (a) The North Carolina Health Planning Commission shall convene a committee to evaluate and report on how governmental programs could become more

prudent purchasers and arrangers of health care. The committee shall be comprised of the following:

(1) The Director of the Division of Medical Assistance of the Department of Human Resources,
(2) The Commissioner of Insurance, or his designee,
(3) The Secretary of the Department of Human Resources, or his designee,
(4) The Secretary of the Department of Environment, Health, and Natural Resources, or his designee
(5) The State Budget Officer,
(6) The Chairs of the Senate and House Appropriations Committees,
(7) The Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan,
(8) A representative from the North Carolina League of Municipalities, and
(9) A representative of the North Carolina Association of County Commissioners.

(b) The Fiscal Research Division of the Legislative Services Office shall identify total health care dollars spent for services provided under the following:

(1) Medicaid program,
(2) Teachers' and State Employees' Comprehensive Major Medical Plan,
(3) Mental Health, Developmental Disabilities, and Substance Abuse Services program,
(4) Local and statewide public health programs,
(5) Health services provided through public school programs and the Department of Corrections, and
(6) Other publicly funded health programs.

(c) Using the information provided under subsection (b) of this section, as well as other information obtained by the committee, the committee shall report its findings and recommendations to the Governor, the Joint Legislative Commission on Governmental Operations, and the North Carolina Health Planning Commission, not later than May 1, 1996.

PART VII – PUBLIC HEALTH STUDY COMMISSION

Sec. 7.1. (a) G.S. 120-196 reads as rewritten:

"**§ 120-196. Commission duties.**

The Commission shall study the availability and accessibility of public health services to all citizens throughout the State. In conducting the study the Commission shall:

(1) Determine whether the public health services currently available in each county or district health department conform to the mission and essential services established under G.S. 130A-1.1;
(2) Study the workforce needs of each county or district health department, including salary levels, professional credentials, and continuing education requirements, and determine the impact that shortages of

public health professional personnel have on the delivery of public health services in county and district health departments;

(3) Review the status and needs of local health departments relative to facilities, and the need for the development of minimum standards governing the provision and maintenance of these facilities;

(4) Propose a long-range plan for funding the public health system, which plan shall include a review and evaluation of the current structure and financing of public health in North Carolina and any other recommendations the Commission deems appropriate based on its study activities; ~~and~~

(5) Conduct any other studies or evaluations the Commission considers necessary to effectuate its ~~purpose.~~ purpose; and

(6) Study the capacity of small counties to meet the core public health functions mandated by current State and federal law. The Commission shall consider whether the current county and district health departments should be organized into a network of larger multi-district community administrative units. In making its recommendations on this study, the Commission shall consider whether the State should establish minimum populations for local health departments, and if so, shall recommend the number of and configuration for these multi-county administrative units and shall recommend a series of incentives to ease county transition into these new arrangements."

(b) If the Public Health Study Commission is not reauthorized on and after June 30, 1995, then the Legislative Research Commission shall undertake the study required of the Public Health Study Commission under G.S. 120-196 as amended by subsection (a) of this section.

PART VIII – EFFECT OF HEADINGS

Sec. 8.1. The headings to the Parts of this act are a convenience to the reader and are for reference only. The headings do not expand, limit, or define the text of this act.

PART IX – EFFECTIVE DATE

Sec. 9.1. Sections 2.1 through 2.8 of this act become effective October 1, 1995, and apply to contracts and agreements entered into on or after that date. The remainder of this act is effective upon ratification.