GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1995

H **2**

HOUSE BILL 288
Committee Substitute Favorable 5/15/95

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

Sponsors:

Referred to:

February 23, 1995

A BILL TO BE ENTITLED

AN ACT TO ENACT CERTAIN OF THE HEALTH CARE REFORM INITIATIVES RECOMMENDED BY THE NORTH CAROLINA HEALTH PLANNING COMMISSION.

The General Assembly of North Carolina enacts:

PART I – HEALTH CARE FACILITY CHANGES

Section 1.1. 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 and physicians 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 hospitals and physicians. Cost increases make it increasingly difficult for hospitals and physicians in rural areas of North Carolina to offer care.

(3) That changes in federal and State regulations governing hospital and physician operation and reimbursement have constrained the ability of hospitals and physicians to acquire and develop new and improved machinery and methods for the provision of hospital-related and physician-related care.

(4) That cooperative agreements among ~~hospitals and~~ hospitals, between hospitals ~~others~~ and others, and between or among physicians 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 and physicians in North Carolina will remain ~~open~~ available in beneficial service to their communities.

(5) That hospitals and physicians 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, or between or among physicians 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. 1.2. 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, among two or more physicians, between or among physicians and other persons, or between a hospital 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.~~ hospitals and physicians. 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 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 required to be licensed under Chapters 131E or 122C of the General Statutes.

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

(7) 'Physician' means an individual licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes."

Sec. 1.3. G.S. 131E-192.3 reads as rewritten:

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

(a) A hospital or a physician and any person who is a party to a cooperative agreement with a hospital or physician 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. 1.4. 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 and~~ hospital-related or physician-related care provided to North Carolina citizens.

(2) Preservation of hospital facilities or physicians in geographical proximity to the communities traditionally served by those facilities.

(3) Lower costs of, or gains in, the efficiency of delivering hospital or physician services.

(4) Improvements in the utilization of hospital or physician resources and equipment.

(5) Avoidance of duplication of hospital or physician 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:

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

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

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

(10) 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, physicians, allied health care professionals, or other health care providers.

(11) 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.

(12) 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."

PART II – HEALTH DATA COLLECTION/PROFESSIONAL LICENSING BOARDS

Sec. 2.1. 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 certain health care providers.**

(a) Occupational licensing boards having authority to license or certify physicians, physician assistants, nurse practitioners, and nurse midwives in this State shall modify procedures for license renewal to include the collection of information specified in this section for each board's regular renewal cycle. 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 subject to this section, in consultation with the North Carolina Health Planning Commission, shall collect, report, and update the following information:

(1) Area of health care specialty practice;

(2) Address of all locations where the licensee practices; and

(3) Other information the occupational licensing board in consultation with the North Carolina Health Planning Commission 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 Planning Commission. 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. 2.2. 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 Planning Commission and shall be updated on an annual basis:

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

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

(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 III – PRIMARY CARE PROVIDERS

Sec. 3.1. (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. 3.2. G.S. 143-613 reads as rewritten:

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

(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 State-operated 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 State-operated 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~~ State-operated medical schools and State-operated 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 who were State-supported graduates 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. 3.3. Effective with each school's 1997-98 fiscal year, each State-operated 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.

PART IV – NORTH CAROLINA HEALTH PLANNING COMMISSION REORGANIZATION

Sec. 4.1. 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. 4.2. 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; ~~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~~ may 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; and

(26) Mechanisms to provide for the continuing education and training of health care personnel. ~~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) Monitor how closely health expenditures for both the public and private sectors relate to the rate of real economic growth, and 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 Teachers' and State Employees' Comprehensive Major Medical 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 crosscut by both public and private source of payment and type of service provider.

In evaluating the data, the Commission shall determine the sectors of the health care system that are growing the fastest, and shall educate the public and government leaders about the real cost of delivering health care to North Carolinians;

(6) Review current conflict of interest laws;

(7) Assess the impact of locum tenens programs;

(8) 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;

(9) Review proposals on collaborative practice;

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

(11) Develop other ways to expand coverage to uninsured persons; and

(12) 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. 4.3. The Commission shall include in its reports to the General Assembly proposed legislation needed to implement recommendations of the Commission.

Sec. 4.4. (a) The North Carolina Health Planning Commission shall evaluate and report on how governmental programs could become more prudent purchasers and arrangers of health care.

(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 Correction, and

(6) Other publicly funded health programs.

(c) Using the information provided under subsection (b) of this section, the Commission shall report its findings and recommendations to the Governor and to the Joint Legislative Commission on Governmental Operations not later than May 1, 1996.

Sec. 4.5. (a) The North Carolina Health Planning 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) 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 multidistrict 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 multicounty administrative units and shall recommend a series of incentives to ease county transition into these new arrangements.

(b) The Commission shall report its findings and recommendations, including proposed legislation, to the Joint Legislative Commission on Governmental Operations on or before May 1, 1996.

PART V – COMMUNITY HEALTH INITIATIVES

Sec. 5.1. (a) Every county in the State shall develop an interagency plan to coordinate 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 services 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 VI – EFFECT OF HEADINGS

Sec. 6.1. 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 VII – EFFECTIVE DATE

Sec. 7.1. Sections 1.1 through 1.4 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.