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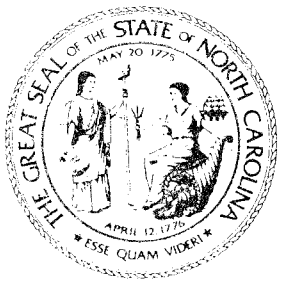
PUBLIC HEALTH FACILITIES



REPORT TO THE 1983 GENERAL ASSEMBLY OF NORTH CAROLINA 1984 SESSION

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LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

June 7, 1984

TO THE MEMBERS OF THE 1983 GENERAL ASSEMBLY (1984 SESSION):

The Legislative Research Commission herewith reports to the 1983 General Assembly, Second Regular Session 1984, on the matter of public health facilities. This report is made pursuant to House Bill 1142 (1983 Session Laws, Chapter 905) of the 1983 General Assembly.

This report was prepared by the Legislative Research Commission's Committee on Public Health Facilities and is transmitted by the Legislative Research Commission for your consideration.

Respectfully submitted,

Liston B. Ramsey

W. Craig Lawing

Cochairmen

Legislative Research Commission

TABLE OF CONTENTS

INTRODUCTION

The Legislative Research Commission, created by Article 6B of General Statutes Chapter 120, is authorized pursuant to the direction of the General Assembly "to make or cause to be made such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" and "to report to the General Assembly the results of the studies made," which reports "may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recommendations." G.S. 120-30.17. The Commission is chaired by the Speaker of the House of Representatives and the President Pro Tempore of the Senate, and consists of five representatives and five senators, who are appointed respectively by the Cochairmen. G.S. 120-30.10(a). (See Appendix A for a list of the Commission members.)

Pursuant to G.S. 120-30.10(b) and (c) the Commission Cochairmen appointed study committees consisting of legislators and public members to conduct the studies. Each member of the Legislative Research Commission was delegated the responsibility of overseeing one group of studies and causing the findings and recommendations of the various committees to be reported to the Commision. In addition, one senator and one representative from each study committee were designated Cochairmen.

By House Bill 1142 (1983 Session Laws, Chapter 905), the

Legislative Research Commission was authorized to study public health facility laws. In order to accomplish these tasks, Senator Russell Walker, as a member of the Legislative Research Commission, was appointed to coordinate and oversee the Study of Public Health Facilities. Senator Anthony E. Rand and Representative Marvin D. Musselwhite, Jr., were appointed to cochair the Committee. Other members appointed were Senators Harold W. Hardison, William H. Hancock, Jr., William W. Redman, Jr., and James D. Speed; and Representatives Tom C. Womble, Charles D. Woodard, William T. Grimsley and W. Paul Pulley, Jr. The Legislative Services Office provided staff assistance to the Committee for this study.

The minutes of the Committee meetings reflect the statements and discussions of each meeting. All of this information is included in the Committee files. (See Appendix B for a listing of persons appearing before the Committee.)

BACKGROUND

For centuries hospitals have been operated with a simple belief. Care was given to whomever needed the service; payment was considered secondarily, but for the past hundred years, with the advancement of scientific medicine and the increased sophistication of these facilities, there is often considerable doubt about which consideration comes first, service or payment.

Hospitals have undergone tremendous pressures and changes since the end of World War II because of an enormous population explosion and great advances in medicine. Our facillities proved inadequate. Therefore, Congress in 1946 passed the Hill-Burton Act which provided federal funding for hospital construction. In order to qualify for these funds, hospitals had to be non-profit, which caused many physician owned-proprietary hospitals to be transferred to local government or to autonomous community non-profit corporations. This tap of federal funds was turned off in 1976. Therefore, in order to make major capital improvements, hospitals have been forced to use accumulated reserves or go into debt.

Other federal payment programs for hospital care have also had a great impact on hospitals. Medicare, a program to provide health services to the elderly, and medicaid, a program that purchases health services for the poor, both began in 1966. In the early years, medicare paid hospitals their costs plus a small profit. For medicaid, about 67% of the funds come from federal monies, the rest from State and county sources. The costs of these programs quickly exceeded all expectations and over the years the gap has widened between what a hospital

receives for these federally sponsored patients and the actual cost of their care.

There are now 147 non-federal hospitals in North Carolina. Of these, 1/5 or 34 hospitals are either owned or managed by investor-owned corporations. Of these 34, 21 are actually owned by investor-owned companies, while 12 are managed by investor-owned companies. One hospital operates under a consulting contract. By contrast, at the end of 1980, 10 North Carolina hospitals were either owned or contract managed by investor-owned organizations. Seven of the 10 were affiliated with multi-hospital, investor-owned systems.

These figures seem to show that since 1980, the number of investor-owned hospitals in North Carolina has increased at a rapid rate. This recent rapid growth in the number of investor-owned hospitals represents a significant new direction in health care in North Carolina.

The last Session of the General Assembly recodified Chapter 131 of the Public Hospital Law. As the Joint House-Senate Subcommittee studied the bill many issues surfaced that had to be resolved. One of the most hotly debated issues dealt with the sale or lease of city or county hospitals to investor-owned corporations. This issue surfaced when an amendment to the recodification bill was introduced in the Joint Subcommittee which would allow a public hospital to lease its facility to a non-profit corporation. From this grew the question of selling such facilities to investor-owned corporations. There was much debate and concern in the Subcommittee about whether the public hospital would continue to serve all the people it has historically served under county/city operation if a for-profit assumed responsibility for the hospital. Ultimately, the Subcommittee and the General Assembly adopted

an interim measure--effective until July 1, 1984, that prevents sale of any but surplus property but allows leases of up to ten years (G.S. 131E-7(e) and G.S. 131E-23(c). There is, however, new authority to sell a city or county hospital to non-profit organizations. (G.S. 131E-8).

Two other issues were added to the Study. The first relates to the definition of an ambulatory surgical facility that has the option of being licensed. It is same day surgery involving no overnight stay. An amendment proposed to the Joint Subcommittee would change the definition of ambulatory surgical facility to include providing up to 72 hours of care. It was argued in Subcommittee that this new definition would change the whole concept of ambulatory surgery. Since there were strong arguments on both sides, the issue was included in this Study.

The final issue referred to in the Study relates to conflict of interest problems for governing bodies of hospital authorities.

COMMITTEE PROCEEDINGS

To execute the charge of House Bill 1142(1983 Session Laws, Chapter 905), The Committee on Public Health Facilities held four meetings: February 9, 1984, February 20 and 21, 1984 and April 13, 1984. At the first meeting the Committee received information on the structure and statutory authority of public hospitals in North Carolina. The Committee also examined the economics of hospital care in North Carolina and heard testimony on the related issues of health care costs in North Carolina.

Members of the Committee spent many hours soliciting first-hand information from hospital administrators, county commissioners, insurance officials and others, concerning trends and the effect of these trends on health care and hospitals in North Carolina. From testimony presented, there seemed to be some readily identifiable trends that will affect health care in the next few years: (1) a continued rise in health care costs; (2) increasing competition for the paying patient and a growth in out-patient health services, both in hospitals and in free-standing units; (3) a possible double standard of care; and (4) greater concern by the private sector in controlling the cost of health care for its employees.

It was obvious from testimony from various experts that the number of investor-owned hospitals is increasing in North Carolina. The Committee heard much testimony about this increase and what it meant for North Carolina. At this time the data do not suggest that county-owned hospitals are diminishing and are being consumed by investor-owned corporations. Only three of the 34 hospitals affiliated with investor-owned corporations were originally public hospitals owned by

the county. Investor-owned corporations in this State have primarily bought independent proprietary hospitals. This practice may change in the future.

Hospital administrators of two of the previously public hospitals and the county commissioners involved, related to the Committee the factors that precipitated the sale of their hospitals to investor-owned corporations. For instance, in Edgecombe County, after 25 mostly successful years, Edgecombe General Hospital was losing money to the point that it was becoming a burden on the county. Surveys indicated that 60% of the patients in this service area were migrating to hospitals in Wilson, Greenville, and Rocky Mount. In 1979 the hospital had a $2 million obligation, had declining patient occupancy and inadequate and out-of-date equipment, Therefore, the county commissioners decided to sell.

There seems to be an accepted profile of the public hospital that becomes a candidate for sale. It is typically an aging institution with a substandard plant and equipment and a weak financial structure. It is located outside a major metropolitan area and is therefore supported by a relatively small tax base. This profile fits many hospitals in North Carolina.

The Committee heard much testimony on how investor-owned and non-profit differed. One difference is tax status. Investor-owned hsopitals must pay federal, state and local taxes, whereas, non-profit hospitals do not. Additionally, investor-owned hospitals cannot receive tax deductible donations or be eligible for government grants.

Another difference between the two is their source of capital. Investor-owned firms have access to equity capital markets, whereas, non-profit corporations rely upon philanthropic donations and bonds for capital needs.

Both investor-owned and non-profit hospitals need to generate an excess of revenue over operating expenses. The kinds of financial requirements that are funded through any hospital's "profit" are:

(1) Cash flow needed to avoid such things as borrowing at inopportune times, forfeiting purchase discounts, or even becoming insolvent.

(2) Replacement of existing equipment or the purchase of new equipment for continued or improved operations.

(3) Funds for renovations, expansion or replacement of facilities and services important to providing higher quality of health care.

In addition to these common needs, investor-owned hospitals must also provide dividends to stockholders.

An underlying question for the Committee was whether there are significant charge differences between for-profit and non-profit hospitals because of the potential impact on the state's responsibilities for health care. The Committee learned that Blue Cross and Blue Shield of North Carolina had completed a study of average charges to Blue Cross subscribers in 1981-82 for three procedures in proprietary hospitals in North Carolina. Although the study had been conducted for the private use of Blue Cross, the Committee prevailed upon Blue Cross to release the study to them.

The findings of the Blue Cross study were that charges were higher for six proprietary hsopitals than for six other hospitals of similar size in North Carolina. The procedures checked were charges for normal deliveries, hysterectomies and gall bladder removals. It was interesting to the Committee that room rates were fairly comparable but the origin of

higher charges was in ancillary charges such as pharmacy, medical-surgical supplies, and, to some extent, operating rooms and anesthesia. The study was criticized because it examined only a small number of procedures in a small number of hospitals, but it is consistent with some other national studies like the Lewin, Patterson, and Katz studies and the Florida Hospital Cost Containment Board Study.

Much of the testimony before the Committee centered around the possible advantages and disadvantages of investor-owned hospitals. Since one of the distinguishing features of American medicine throughout its modern history has been the importance of non-profit organizations in the provision and financing of medical care, the Committee was extremely interested in the comparisons of advantages and disadvantages as they related to the possible need for recommendations to the General Assembly.

The North Carolina Center for Public Policy Research was extremely useful to the Committee in helping it to understand the movement toward investor-owned hospitals because it is the only organization presently engaged in definitive research into implications of for-profit enterprise in health care in North Carolina. Although its investigations are not complete, it has summarized some of the possible advantages and disadvantages of affiliation with investor- owned corporations.

The possible advantages are:

(1) Access to private capital. In situations where there is a 25-35 year-old community hospital built with Hill-Burton funds, private for-profit hsopitals may have an advantage over public hospitals in access

to investment capital. Public hospitals usually depend on tax-expempt bonds for new construction financing.

(2) Management expertise. Investor-owned corporations are in the business of operating hospitals, whereas many others who run hospitals in North Carolina are simply not experts in the field.

(3) Volume purchasing. Any multi-institutional system has the advantage of saving money through large volume purchases of basic medical necessities like intravenous solutions. A single hospital usually cannot approach the buying power or the sophisticated inventory control of an investor-owned corporation.

(4) Promoting competition in the hospital sector. This benefit is most often seen in urban areas with more than one hospital, but a recent edition of the public television program "Frontline" perhaps best depicted how all hospitals are increasingly following some practices that heretofore were more charactarestic of for-profit than non-profit hospitals.

(5) Tax advantages. If the hsopital changes from county-owned or other public facility to a profit facility, it also changes from being tax supported to being tax paying, simply because for-profit hospitals are subject to local property taxes and corporate tax levies.

(6) Taking the County out of the hospital business. Only schools seem to provoke as many problems for county officials as do hospitals. County officials are often glad to let the responsibility for the local hospital rest with someone else, particularly if the county will be able to stop appropriating money to the hospitals and gain a taxpayer. Even if the hospital is not wholly a public facility, counties often appropriate a certain amount to the local hospital for indigent care. This advantage is as much related to politics as to economic questions.

The possible disadvantages are:

(1) For-profit hospitals may have higher charges. This is seen in the Blue Cross Study.

(2) Indigent care. A major concern expressed about hospitals affiliated with investor-owned corporations is whether they provide less indigent care than do not-for-profit hospitals. This is an area where there seems to have been more talk than research.

(3) Skimming the cream. This may be a problem if the hospitals affiliated with investor-owned corporations narrow the range of services offered in a hospital or alter the patient mix such that for-profit hospitals get more of the paying patients--usually those with private health insurance--leaving fewer such revenue-producing patients or services for other non-for-profit hospitals.

(4) Changing the nature of health care. Just as there is a political factor that may be an advantage of investor-owned hospitals, there is a philosophical factor that may be a disadvantage. This can be best expressed as a question about whether cost or profit considerations properly belong in the delivery of health care. For those raising this question, hospital care is perceived to be a public good guaranteed almost by right to every American. At this point, research questions end, and the discussion shifts to individual views about who has the responsibility for delivery of health care in a democratic society.*

* This summary was done by the North Carolina Center for Public Policy Research for the Institute of Medicine and made available to this Committee.

F I N D I N G S

Pursuant to the direction of House Bill 1142 (1983 Session Laws, Chapter 905), the Legislative Research Commission's Committee on Public Health Facilities, after having reviewed the information presented, makes the following findings as listed below:

FINDING 1. THERE IS A SIGNIFICANT RECENT TREND IN HEALTH CARE IN NORTH CAROLINA TOWARDS RAPID GROWTH IN THE NUMBER OF HOSPITALS OWNED OR MANAGED BY NATIONAL INVESTOR-OWNED CORPORATIONS.

North Carolina has always had a number of independent proprietary hospitals, usually started by a few local doctors operated on a for-profit basis, as well as a number of public hospitals. But this picture is changing. Since 1977 thirty of the independent proprietary hospitals and three public hospitals have been sold to national investor-owned corporations.

There is an accepted profile of the public hospital that is a good candidate for sale. It is typically an aging institution with a substandard plant and equipment and a weak financial structure. Because this profile fits many public hospitals in North Carolina, the Committee believes that there is no reason to think that the trend toward the sale of these public hospitals to national investor-owned corporations will not continue.

FINDING 2. THE COMMITTEE BELIEVES THAT THE GENERAL ASSEMBLY OF NORTH CAROLINA HAS A COMPELLING INTEREST IN THIS SIGNIFICANT NEW HEALTH CARE TREND.

The General Assembly has stopped the clock on the sale of public hospitals to for-profit corporations through the imposition of a moratorium. The clock begins to tick again July 1, 1984, with the expiration of the moratorium. If the decision of the General Assembly is that there is no further State interest in the question, then other forces will push our hospital systems to some ultimate conclusion unguided by legislative

input and State oversight.

The data before the Committee would suggest that State government will be greatly affected regardless of whether it takes an active role simply because the State is such a large payer of health care costs.

All institutions of healing have to attend both to the canons of ethics and to the canons of economics. The danger is that the canons of economics may be more visible in the case of the investor-owned hospital, but it is by no means absent from the traditional nonprofit institution. Therefore government must have a concern for any hospital institution as a social enterprise rather than as a corporate entity. It is the healing mission, not the corporate organism, that the State needs to protect.

It is an historical assumption that public hospitals have a commitment to everyone who lives in an area. Will the transferred hospital continue to serve all of the people it has historically served under county/city operation? How will the range and amounts of service be affected? Will independent medical vendors be free to choose as patients only people with good insurance and acceptable credit? Will these changes lead to a dual system of health care--one for insured patients and an inferior one for public patients? How will these changes impact on the state budget as it relates to state-funded medical payment programs? The State has a compelling interest that these questions be answered according to the health needs of citizens of the State rather than any purely economic requirements.

FINDING 3. LOCAL GOVERNMENTS SHOULD BE GIVEN AS MANY AVAILABLE OPTIONS AS POSSIBLE IN DEALING WITH THE CHANGES IN THEIR LOCAL HOSPITAL SITUATIONS. THEIR INTEREST AND THE STATE'S INTERESTS WILL BEST BE

SERVED BY ALLOWING THE MORATORIUM ON THE SALE OF HOSPITAL FACILITIES TO FOR-PROFIT CORPORATIONS TO EXPIRE.

Providing health care in publically controlled hospitals increasingly appears to many local officials as a no-win situation as they are caught between rising costs and decreased federal funding. The Committee recognizes that many problems and potential crises exist for many localities as they face these issues. The Committee believes that many of the decisions affecting hospital care in a local area are best left to the municipalities.

The Committee also recognizes the historic partnership that has existed between the counties and the State in providing and maintaining adequate health care resources at the local level. There seems to be some danger that financial difficulties in some hospitals threaten to disturb this county/State partnership. One of the ways the State should help in restoring some equilibrium is to establish statutorily a process by which all counties can address their local hospital situation.

The State also has some need to continue, foster, and protect those programs which it has helped to establish and fund in local public hospitals. Some local hospitals have received State-appropriated funds that have been used for capital expenditures. This is the case for vocational rehabilitation programs, perinatal programs, and Area Health Education Centers. The sale of the local hospital to a for-profit corporation does not necessarily negate the need for the program nor does it cancel the State's financial interest.

FINDING 4. THE CURRENT DEFINITION OF AN AMBULATORY SURGERY FACILITY DOES NOT PROVIDE AN ADEQUATE STATUTORY BASIS FOR THE DEVELOPMENT OF

APPROPRIATE CRITERIA AND STANDARDS FOR LICENSING OF AMBULATORY SURGERY PROGRAMS.

Ambulatory surgery is surgery that does not require hospitalization. For this reason the experts believe that it can be an important method for helping to reduce rising hospital costs. Testimony before the Committee suggests that the current statutory language is not sufficient for the development of a sound and cost efficient program in ambulatory care.

Problems with the current definition in G.S. 131E-176 are:

(1) It is possibly unconstitutional because it is not applied equally to all health facilities that meet the definition because licensure is elective;

(2) It is outdated as it no longer defines what is considered by the experts to be an ambulatory surgical facility; and

(3) It does not identify appropriate levels of surgical care for ambulatory surgical facilities.

RECOMMENDATIONS

RECOMMENDATION 1. THE MORATORIUM ON THE SALE OF PUBLIC HOSPITALS TO INVESTOR-OWNED CORPORATIONS SHOULD NOT BE REIMPOSED AFTER THE EXPIRATION JULY 1, 1984, IF THE GENERAL ASSEMBLY PASSES LEGISLATION ESTABLISHING SOME SAFEGUARDS FOR THE GENERAL PUBLIC AND NEW PROCEEDURAL REQUIREMENTS, LIKE PUBLIC NOTICE AND HEARINGS, BEFORE ANY PUBLIC HOSPITAL IS SOLD OR LEASED TO AN INVESTOR-OWNED CORPORATION. (See Appendix E.)

The proposed legislation contained in Appendix E is in three parts, one part dealing with the lease of a hospital by a municipality, one dealing with the lease of a hospital authority, and one dealing with the sale of a hospital by a municipality or a hospital authority. Each part is substantially the same. The first paragraph of each part adds to the present law's guarantee of continued nondiscriminatory service to the general public, and to indigents in particular. A specific guarantee of specific essential services' continuation is added. The bill also permits termination of services, upon certain specified proceedures. Both subleases and succeeding sales are made subject to the same conditions as are the initial leases and sales. The sales paragraph has a reverter provision, slightly expanded from current law, to apply to succeeding sales, further to guarantee compliance with the provisions.

The second paragraph of the lease sections and the fourth paragraph of the sale section are new and spell out the due process proceedures the public entity must follow before leasing or selling a public hospital. The proceedures require notice of intent to lease or sell, solicitation of proposals, request for Statements of Information, holding of a public

hearing, a final public meeting to approve or deny the sale or lease, and the submission of an annual report from the lessee or buyer.

RECOMMENDATION 2. THE GENERAL ASSEMBLY SHOULD PASS LEGISLATION TO ASSURE THE PUBLIC THAT AREA HEALTH EDUCATION CENTER FACILITIES AND ACTIVITIES ARE MAINTAINED ON AN EQUIVALENT BASIS REGARDLESS OF HOSPITAL OWNERSHIP OR MANAGEMENT IN THOSE AREAS OF THE STATE WHERE AREA HEALTH EDUCATION CENTERS HAVE BEEN ESTABLISHED. (See Appendix F.)

The State, historically, has helped to foster and maintain a partnership in the provision of local hospital and health care. One of the premier examples of this partnership is the Area Health Education Center Program (AHEC). The General Assembly has appropriated funds to provide capital grants which have helped in the construction of educational facilities necessary to carry out the AHEC Program. Facilities in some instances are located as part of the hospital campus and may be affected if a hospital is sold to an investor-owned corporation.

To protect the State's interest in the AHEC Program and facilities, the proposed legislation in Appendix F would require that the municipality or hospital authority give specific notice of intent to sell or lease and of the public hearing to the director of the local AHEC Program and the director of the AHEC Program at U.N.C. School of Medicine.

The legislation would also allow the municipality or hospital authority to provide continued access to identical or equivalent facilities suitable for continuation of AHEC activities. The municipality or hospital authority may convey all ownership rights in a free-standing portion of the hospital facility to the local AHEC Program without monetary consideration.

RECOMMENDATION 3. THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD AMEND 131E-176 TO PROVIDE AN ADEQUATE DEFINITION FOR AMBULATORY SURGICAL PROGRAM AND AMBULATORY SURGICAL FACILITY. (See Appendix G.)

The proposed legislation includes the following:

(1) A clear definition that ambulatory surgery is same day surgery, not requiring hospitalization, and not requiring overnight stay; and

(2) A statement that licensure would be required if a facility is performing ambulatory surgery according to the proposed definition.

RECOMMENDATION 4. THE NORTH CAROLINA GENERAL ASSEMBLY SHOULD ENACT LEGISLATION TO MAKE THE HOSPITAL AUTHORITY LAW CONSISTENT WITH THE GENERAL CRIMINAL STATUTE ON CONFLICT OF INTEREST. (See Appendix H.)

Subsequent to the 1983 Session, the Attorney General's Office issued several opinions to public hospitals which indicated that (a) a physician member of the board of trustees may not contract with the hospital to provide medical services; (b) a member of the board, who is a stockholder of a company may not allow his company to transact business with the public hospital, and (c) an employee of a major local industry may not allow his company to buy health services by agreement from a public hospital. HB 1062 was introduced and passed in 1983 Session to provide an exception for public officials who are members of the board of trustees of public bodies, including hospitals which may transact business with a corporation where the board member is a stockholder of ten percent or less of stock of a corporation or ten percent or less of ownership in any other business entity, or an employee

of the corporation or business entity so long as the public official does not participate in the vote. This language was codified in G.S. 14-234.

The proposed bill in Appendix H would take the language in G.S. 14-234 and place it in G.S. 131E, the Hospital Authority Law, so that there is no future confusion about its applicability.

A P P E N D I C E S

APPENDIX A

STATE OF NORTH CAROLINA

LEGISLATIVE RESEARCH COMMISSION

STATE LEGISLATIVE BUILDING

RALEIGH 27611

1983-1985

LEGISLATIVE RESEARCH COMMISSION MEMBERSHIP

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Representative John T. Church	Senator William N. Martin
Representative Bruce Ethridge	Senator Helen Rhyne Marvin
Representative Chris S. Barker, Jr.	Senator William W. Staton
Representative John J. Hunt	Senator Joseph E. Thomas
Representative Margaret Tennille	Senator Russell Walker

APPENDIX B

PEOPLE WHO APPEARED BEFORE THE COMMITTEE

Mr. Bryan Aldrich
Administrator
Rocky Mount Hospital

Mr. Cam Camalier
N. C. Medical Society

Mr. Ed Childs
Assistant Vice President
Acquisition and Development
Hospital Corporation of America

Dr. James Cooney
Director of Graduate Program
Hospital Administration
Duke University

Mr. Harry Ferris
Administrator
Raleigh Community Hospital

Mr. J. D. Foust
Secretary
Local Government Commission

Dr. Sandra Greene
Director
Health Economics Research
BCBS of North Carolina

Mr. K. S. Harmon
Former County Commissioner
Lee County

Dr. John Henley
Ear, Nose, Throat Specialist
Fayetteville

Dr. Barbara Kramer
Section Chief
Division of Facility Services

Ms. Lacey Maddox, Attorney
N. C. Center of Public Policy
Research

Mr. C. B. Martin, Chairman
Board of County Commissioners
Edgecombe County

Mr. Steve Morrisette
Vice President
N. C. Hospital Association

Ms. Karen Murphy, Attorney
N. C. Hospital Association

Mr. Lou Orban
Director of Planning
N. C. Memorial Hospital

Mr. Lewis Ridgeway
Executive Director
Edgecombe Hospital

Mr. Phil Shaw
Executive Director
Central Carolina Hospital

Mr. Duncan Yaggy
Chief Planning Officer
Duke University Hospital

APPENDIX C

INVESTOR-OWNED INVOLVEMENT *

	Name	Location	Number Beds	Type	Owned/ Managed	Date
1	Hickory Memorial	Hickory	47	G	O-UMC	1979
2	Glenn Frye Memorial	Hickory	218	G	O-AMI	1974
3	Gordon Crowell Memorial	Lincolntown	93	G	O-AMI	1972
4	Davis Memorial	Statesville	167	G	O-HCA	1983
5	Medical Park	Winston-Salem	136	G	O-Ind.	1971
6	Humana Hospital	Greensboro	100	G	O-Humana	1977
7	Central Carolina	Sanford	142	G	O-AMI	1980
8	Highsmith-Rainey	Fayetteville	95	G	O-HCA	1983
9	Raleigh Community	Raleigh	140	G	O-HCA	1977
10	Rocky Mount Sanitarium	Rocky Mount	50	G	O-AMI	1981
11	Edgecombe General	Tarboro	127	G	O-HCA	1982
12	Highland	Asheville	125	P	O-PIA	1981
13	Appalachian Hall	Asheville	100	P	O-PIA	1981
14	Orthopaedic Hospital	Charlotte	166	S	O-HCA	1982
15	Charlotte EE&T	Charlotte	68	S	O-Humana	1981
16	Mandala Center	Winston-Salem	75	P	O-CMC	1981
17	Charter Hills	Greensboro	100	P	O-CMC	1981
18	McPherson	Durham	32	S	O-Ind.	1926
19	Cumberland Psychiatric	Fayetteville	108	P	O-HSA	1983
20	Holly Hill	Raleigh	58	P	O-HCA	1981
21	Brynn Marr Treatment Center	Jacksonville	90	P	O-HSA	1983
22	District Memorial of Southwestern N.C.	Andrews	61	G	M-Delta	1979
23	Angel Community	Franklin	81	G	M-HCA	1983
24	Blue Ridge	Spruce Pine	92	G	M-HCA	1982
25	Marion General	Marion	62	G	M-Delta	1982
26	Ashe Memorial	Jefferson	76	G	M-HCA	1981
27	Person County	Roxboro	88	G	M-HCA	1981
28	Cape Fear Valley	Fayetteville	473	G	M-NME	1982
29	Johnston Memorial	Smithfield	180	G	M-HCA	1982
30	Brunswick County	Supply	60	G	M-HCA	1981
31	Franklin Memorial	Louisburg	76	G	M-HCA	1983
32	Craven County	New Bern	248	G	HCA - consulting contract	1982
33	Lowrance Hospital	Mooresville	121	G	M-HCA	1983
34	Morehead Memorial	Eden	133	G	M-HMP	1984

* * * * * * * * * * * * * * * * * *

G - General hospital (primarily)
P - Psychiatric
S - Specialty
O - Owned
M - Managed

Full names for the corporations listed above are as follows:

AMI .....American Medical International
CMC/Charter ..Charter Medical Corporation
Delta .....The Delta Group, Inc.
HCA .....Hospital Corporation of America
HMP .....Hospital Management Professionals
HSA .....Healthcare Services of America
Humana .....Humana, Inc.
Ind.....Independently owned, not affiliated with a chain
NME .....National Medical Enterprises, Inc.
PIA .....Psychiatric Institutes of America
UMC .....United Medical Corporation

* Provided by the North Carolina Center for Public Policy Research Inc.

AMBULATORY SURGICAL FACILITIES

CURRENT SITUATION:

- **Definition of Ambulatory Surgery Facility Very General.**
  - "A Facility which provides surgical treatment to patients not requiring hospitalization."
  - Does not include hospital ambulatory surgery.
  - Includes physicians' offices if they elect to apply for licensure.
- **Existing Licensure attempts to cover various types of facilities without making a distinction in procedures performed.**
- **The following table illustrates the existing and proposed variety of facilities in North Carolina licensed as Ambulatory Surgical Facilities.**

EXISTING	CON APPLICATION APPROVED OR IN REVIEW PROCESS
Licensed Freestanding (18)	Freestanding (25)
• **10 Specialty** OB-GYN Cardiovascular Hand Birthing Abortion Eye	• **8 Specialty** Eye Plastic Surgery Clinic for Women
• **8 Multi-Specialty**	• **17 Multi-Specialty** (4 of which are to be hospital based but are seeking separate license)
In Hospitals Not Licensed Separately	
• **Approx. 60 Multi-Specialty**	

PROBLEMS WITH CURRENT DEFINITION IN G.S. 131 E-176

(Licensing of Ambulatory Surgery Facilities)

- **Probably unconstitutional** - is not applied equally to all health facilities that meet the definition - licensure is elective.

  Example: Two physicians' offices may be performing essentially the same type of surgery and one may elect to be licensed as an ambulatory surgical facility and the other may not.

- **Outdated** - no longer defines what is considered to be an ambulatory surgical facility.
- **Does not identify appropriate levels of surgical care** for ambulatory surgical facilities.
- **Does not provide adequate statutory basis** for development of appropriate criteria and standards for regulating (licensing) ambulatory surgery programs.

(am.surg.curr.sit.) <h>

PROPOSED CHANGES TO AMBULATORY SURGERY LICENSING LAW

BACKGROUND

A Special Task Force, with representation from the following groups: Medical Profession, Hospital Association, Insurance Industry (incl. Blue Cross and State Health Plan), Division of Medical Assistance, Division of Facility Services (incl. Director's Office, Licensure, Certificate of Need and Health Planning) and Office of the Secretary of DHR; **proposes the following:**

(1) **The definition of an Ambulatory Surgery Facility be changed as proposed below:**

(2) **That the definition of Ambulatory Surgery clearly state the concept that ambulatory surgery is same day surgery, not requiring hospitalization, not requiring overnight stay.**

(3) **If a Facility proposes to perform surgery that would require overnight stay, it falls within the definition of a hospital and should be licensed as such.**

(4) **If a Facility is performing ambulatory surgery according to the proposed definition, licensure should be required.**

PROPOSED DEFINITION

Ambulatory Surgical Program is 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 an overnight stay is determined, prior to surgery, to be medically unnecessary.

Ambulatory Surgical Facility is a facility designed for the provision of an 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 one designated operating room 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 composed of physicians having no financial interest in the facility, and maintain adequate medical records for each patient. An ambulatory surgical facility is not a physician's or dentist's office.

CURRENT DEFINITION

General Statute 131-E-176

Ambulatory surgical facility means a public or private facility, not a part of a hospital, which provides surgical treatment to patients not requiring hospitalization. Such term does not include the offices of private physicians or dentists, whether for individual or group practice, unless they elect to apply for licensure under Chapter 131E, Article 6, Part D of the General Statutes.

APPENDIX E

ST: Public Hospital Sales, Lease

A BILL TO BE ENTITLED

AN ACT TO PROTECT THE PUBLIC INTEREST IN THE SALE OR LEASE OF PUBLIC HOSPITAL FACILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-7 is amended by deleting subsections (d), (e), and (f) and by substituting the following:

"(d) A municipality may lease any hospital facility, or part, to a nonprofit corporation organized under Chapter 55A of the General Statutes or a corporation, foreign or domestic, authorized to do business in North Carolina on terms and conditions consistent with the purposes of this Part and with G.S. 160A-272, except as otherwise stated. The municipality shall determine the length of the lease. Leases of 10 years or less, including options to renew or extend the original terms of the lease, shall be subject to the further provisions of this subsection. Leases for terms of more than ten years shall be subject to G.S. 131E-8, except that the defeasance provisions of G.S. 131E-8(b) shall not apply to leases or renewals made in conjunction with bond or note sales required to be approved or that have been approved by the Local Government Commission. The terms of all leases or renewals shall extend at least until the final maturity of any bonds or notes so approved. The lease shall provide that the hospital facility is legally

obligated to operate as a community general hospital open to the general public, free of discrimination based upon race, creed, color, sex or national origin, and that these services shall be provided to indigent patients, as the municipality and the corporation agree, as described in this subsection and implemented in the lease agreement. The lease shall further provide that the corporation:

(1) shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient, and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the leasing. These services may be terminated only as prescribed by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable, by review procedure designed to guarantee public participation, pursuant to rules promulgated by the Secretary of Human Resources;

(2) if requests are made for that level of care, the corporation shall continue to provide the same percentage of gross revenues in care to individuals with incomes below the federal poverty guidelines that the hospital facility provided on the average for the three years prior to the leasing;

(3) shall not enact financial admission policies that have the effect of denying medically necessary services

or treatment solely because of a patient's immediate inability to pay for the services or treatment;

(4) shall ensure that admission to and services of the facility are available to beneficiaries of the governmental reimbursement programs (Medicaid/Medicare) without discrimination or preference because they are beneficiaries of those programs;

(5) shall ensure that any community service obligation imposed by government grant, loan, or contract shall continue as to the lessee.

No lease executed under this subsection shall be considered to convey a freehold interest. Any sublease or assignment of the lease shall be subject to the conditions prescribed by this section.

Any lease under this subsection is subject to the following procedure:

(1) The municipality shall first adopt a resolution declaring its intent to lease the hospital facility at a regular meeting of the municipality on ten days' public notice. Notice shall be given by publication in one or more papers of general circulation in the affected area describing the intent to lease, the hospital facility to be leased, known potential lessees, a solicitation of additional interested lessees, and intent to negotiate the terms of lease. Specific notice, given by certified mail, shall be given to the local office of each State-supported or

State-administered training, education, and treatment program in the hospital facility that has made a capital expenditure in the hospital facility, to the Department of Human Resources, and to the Office of State Budget and Management.

(2) At least 90 days prior to the proposed date of approval, the municipality shall request lease proposals by:

a. direct solicitation of at least five prospective lessees; and

b. advertising in a national financial journal and in a national health journal.

The proposals shall contain the Statement of Information prescribed in subdivision (3) of this subsection and shall contain any other specifics the municipality considers necessary.

The municipality shall appoint a committee of experts in the health field and in the field of public finance to examine the proposals and to recommend to the municipality during the public hearing and again at the meeting on the lease approval which, if any, will best serve the public interest.

(3) The municipality shall require a Statement of Information from all proposed lessees which includes information on charges, services, and indigent care at hospitals owned or leased in North Carolina, if any, and the most recently acquired hospitals of comparable

size and similar scope located outside North Carolina in the nearest geographic proximity, not to exceed a total of five hospitals, if any. The Department of Human Resources shall develop the Statement of Information form within 30 days of the ratification of this bill. This form shall include the following information:

a. the average total charge, for room plus ancillaries, for the five most frequent surgical procedures, using data from the most recent 12 month period available;

b. the total charge per patient day for room plus ancillaries for each of the past three years;

c. the percent of patient days over the past three years that are Medicaid days, Medicare days, and indigent care days; and

d. what patient services, medical-surgical, obstetrics, pediatrics, outpatient, emergency, have been added or deleted since the lease;

e. the percent of free care provided to individuals with incomes below the federal poverty guidelines, as compared with the gross patient revenues;

f. the percent of racial or ethnic minorities served as compared to the percent of minorities in the hospital facility's service area, as requested by the municipality;

g. the corporation's policy on pre-admission deposits;

h. the corporation's policy for providing emergency services to those persons unable to pay, including the hospital facility's definition of "emergency";

i. copies provided by the corporation of the 1981 patient survey submitted to the Department of Health and Human Services, Office of Civil Rights, or a more recent report, if applicable;

j. a copy provided by the corporation of the most recent 10-K report which is submitted to the Securities and Exchange Commission, if applicable; and

k. a proposal submitted by the corporation for how it will continue to provide services to those persons with incomes below the federal poverty guidelines.

(4) At least 60 days prior to the proposed date of approval the municipality shall make available to the public a copy of the final proposed lease document and the Statement of Information.

(5) At least 60 days prior to the proposed date of approval the municipality shall notify the public of a public hearing on the proposed lease. Public notice shall be posted in the hospital facility; on the principal bulletin board of the municipality; and

mailed or delivered to each newspaper, wire service, radio station, TV station, and State-supported or State-administered program, which has filed a written request for notice. This notice shall describe the hospital to be leased, the proposed monetary consideration or absence of consideration, the governing body's intent to authorize the lease, and the availability of the Statement of Information.

(6) At least 15 days from the publication of the notice and at least 45 days prior to the proposed date of approval, the municipality shall conduct the public hearing. At the public hearing the municipality shall hear all interested persons who appear with respect to whether the lease is in the public interest.

(7) Any lease under this subsection must be approved by the municipality by a resolution adopted at a regular meeting of the governing body on ten days' public notice. The municipality shall adopt this resolution only upon a finding that the lease is in the public interest. Consideration to determine whether the lease is in the public interest shall include a consideration of whether the proposed lease will meet the health-related needs of medically underserved groups, such as low income persons, racial and ethnic minorities, and handicapped persons.

(8) The municipality shall require an annual report from the lessee that shows compliance with the requirements of this subsection.

This subsection shall not apply to leases, subleases, or assignments of specialized services which are services other than those described above in this subsection, or to non-medical services or commercial activities, including the gift shop, cafeteria, the flower shop, or to surplus hospital property that is not required in the delivery of hospital services at the time of lease.

(e) In addition to the general and special powers conferred by this Part, a municipality is authorized to exercise powers necessary to implement the powers under this Part."

Sec. 2. G.S. 131E-23(c) is rewritten to read:

"(c) A hospital authority may lease any hospital facility, or part, to a nonprofit corporation organized under Chapter 55A of the General Statutes or a corporation, foreign or domestic, authorized to do business in North Carolina on terms and conditions consistent with the purposes of this Part. The hospital authority shall determine the length of the lease. Leases of 10 years or less, including options to renew or extend the original terms of the lease, shall be subject to the further provisions of this subsection. Leases for terms of more than ten years shall be governed by G.S. 131E-8, except that the defeasance provisions of G.S. 131E-8(b) shall not apply to leases or

renewals made in conjunction with bond or note sales required to be approved or that have been approved by the Local Government Commission. The terms of all leases or renewals shall extend at least until the final maturity of any bonds or notes so approved. The lease shall provide that the hospital facility is legally obligated to operate as a community general hospital open to the general public, free of discrimination based upon race, creed, color, sex or national origin and that these services shall be provided to indigent patients, as the hospital authority and the corporation agree, as described in this subsection and implemented in the lease agreement. The lease shall further provide that the corporation:

(1) shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient, and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the leasing. These services may be terminated only as prescribed by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable, by review procedure designed to guarantee public participation, pursuant to rules promulgated by the Secretary of Human Resources;

(2) if requests are made for that level of care, the corporation shall continue to provide the same

percentage of gross revenues in care to individuals with incomes below the federal poverty guidelines that the hospital facility provided on the average for the three years prior to the leasing;

(3) shall not enact financial admission policies that have the effect of denying medically necessary services or treatment solely because of a patient's immediate inability to pay for the services or treatment;

(4) shall ensure that admission to and services of the facility are available to beneficiaries of the governmental reimbursement programs (Medicaid/Medicare) without discrimination or preference because they are beneficiaries of those programs;

(5) shall ensure that any community service obligation imposed by government grant, loan, or contract shall continue as to the lessee.

No lease executed under this subsection shall be considered to convey a freehold interest. Any sublease or assignment of the lease shall be subject to the conditions prescribed by this section.

Any lease under this subsection is subject to the following procedure:

(1) The hospital authority shall first adopt a resolution declaring its intent to lease the hospital facility at a regular meeting of the hospital authority on ten days' public notice. Notice shall be given by publication in one or more papers of general

circulation in the affected area describing the intent to lease, the hospital facility to be leased, known potential lessees, a solicitation of additional interested lessees, and intent to negotiate the terms of lease. Specific notice, given by certified mail, shall be given to the local office of each State-supported or State-administered training, education, and treatment program in the hospital facility that has made a capital expenditure in the hospital facility, to the Department of Human Resources, and to the Office of State Budget and Management.

(2) At least 90 days prior to the proposed date of approval, the hospital authority shall request lease proposals by:

a. direct solicitation of at least five prospective lessees; and

b. advertising in a national financial journal and in a national health journal.

The proposals shall contain the Statement of Information prescribed in subdivision (3) of this subsection and shall contain any other specifics the hospital authority considers necessary.

The hospital authority shall appoint a committee of experts in the health field and in the field of public finance to examine the proposals and to recommend to the hospital authority during the public

hearing and again at the meeting on the lease approval which, if any, will best serve the public interest.

(3) The hospital authority shall require a Statement of Information from all proposed lessees which includes information on charges, services and indigent care at all hospitals owned or leased in North Carolina, if any, and the most recently acquired hospitals of comparable size and similar scope located outside North Carolina in the nearest geographic proximity, not to exceed a total of five hospitals, if any. The Department of Human Resources, shall develop the Statement of Information form within 30 days of the ratification of this bill. This form shall include the following information:

a. the average total charge, for room plus ancillaries, for the five most frequent surgical procedures, using data from the most recent 12 month period available;

b. the total charge per patient day for room plus ancillaries for each of the past three years;

c. the percent of patient days for the past three years that are Medicaid days, medicare days, and indigent care days; and

d. what patient services, medical-surgical, obstetrics, pediatrics, outpatient, emergency, have been added or deleted since the lease;

e. the percent of free care provided to individuals with incomes below the federal poverty guidelines, as compared with the gross patient revenues;

f. the percent of racial or ethnic minorities served as compared to the percent of minorities in the hospital facility's service area, as requested by the hospital authority;

g. the corporation's policy on pre-admission deposits;

h. the corporation's policy for providing emergency services to those persons unable to pay, including the hospital facility's definition of "emergency";

i. copies provided by the corporation of the 1981 patient survey submitted to the Department of Health and Human Services, Office of Civil Rights, or a more recent report, if applicable;

j. a copy provided by the corporation of the most recent 10-K report which is submitted to the Securities and Exchange Commission, if applicable; and

k. a proposal submitted by the corporation for how it will continue to provide services to those persons with incomes below the federal poverty guidelines.

(4) At least 60 days prior to the proposed date of approval the hospital authority shall make available to the public a copy of the final proposed lease document and a Statement of Information.

(5) At least 60 days prior to the proposed date of approval the hospital authority shall notify the public of a public hearing on the proposed lease. Public notice shall be posted in the hospital facility; on the principal bulletin board of the hospital authority; and mailed or delivered to each newspaper, wire service, radio station, TV station, and State-supported or State-administered program, which has filed a written request for notice.

This notice shall describe the hospital to be leased, the proposed monetary consideration or absence of consideration, the governing body's intent to authorize the lease and the availability of the Statement of Information.

(6) At least 15 days from the publication of the notice and at least 45 days prior to the proposed date of approval the hospital authority shall conduct the public hearing. At the public hearing the hospital authority shall hear all interested persons who appear with respect to whether the lease is in the public interest.

(7) Any lease under this subsection must be approved by the hospital authority by a resolution adopted at a

regular meeting of the governing body on ten days' public notice. The hospital authority shall adopt this resolution only upon a finding that the lease is in the public interest. Consideration to determine whether the lease is in the public interest shall include a consideration of whether the proposed lease will meet the health-related needs of medically underserved groups, such as low income persons, racial and ethnic minorities, and handicapped persons.

(8) The hospital authority shall require an annual report from the lessee that shows compliance with the requirements of this subsection.

This subsection shall not apply to leases, subleases or assignments of specialized services which are services other than those described above this subsection, or to non-medical services or commercial activities, including the gift shop, cafeteria, flower shop, or to surplus hospital property that is not required in the delivery of hospital services at the time of lease."

Sec. 3. G.S. 131E-8 is rewritten to read:

"131E-8. Sale of hospital facilities.--(a) A municipality as defined in G.S. 131E-6(5) or hospital authority as defined in G.S. 131E-16(14), upon those terms and conditions it considers appropriate, with or without monetary consideration, may sell or convey to a nonprofit corporation organized under Chapter 55A of the General Statutes or a corporation, foreign or domestic, authorized to do business in

North Carolina, any rights of ownership the municipality or hospital authority has in a hospital facility, or part, including the building, land and equipment associated with the hospital, if the corporation is legally obligated to continue to operate the facility as a community general hospital open to the general public, free of discrimination based upon race, creed, color, sex or national origin, and if the corporation also agrees, as a condition of the municipality or hospital authority's conveying ownership, to provide the services to indigent patients as the municipality or hospital authority and the corporation agree, as described in this section and implemented in the agreement of sale. The agreement of sale shall further provide that the corporation:

(1) shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient, and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the leasing. These services may be terminated only as prescribed by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable, by review procedure designed to guarantee public participation, pursuant to rules promulgated by the Secretary of Human Resources;

(2) if requests are made for that level of care, the corporation shall continue to provide the same percentage of gross revenues in care to individuals with incomes below the federal poverty guidelines that the hospital facility provided on the average for the three years prior to the leasing;

(3) shall not enact financial admission policies that have the effect of denying medically necessary services or treatment solely because of a patient's immediate inability to pay for the services or treatment;

(4) shall ensure that admission to and services of the facility are available to beneficiaries of the governmental reimbursement programs (Medicaid/Medicare) without discrimination or preference because they are beneficiaries of those programs;

(5) shall ensure that any community service obligation imposed by government grant, loan, or contract shall continue as to the buyer.

The corporation shall further agree that should it fail to operate a facility as a community general hospital open to the general public or should the corporation dissolve without a successor corporation to carry out the terms and conditions of the agreement of conveyance, or should it fail to convey the hospital facility to a successor in interest that will carry out the terms and conditions of the conveyance, then all ownership rights in the hospital facility, including the building, land and equipment associated with

the hospital shall revert to the municipality or hospital authority or successor entity originally conveying the hospital; provided that any building, land, or equipment associated with the hospital facility which the corporation has constructed or acquired since the sale may revert only upon payment to the corporation of a sum equal to the cost less depreciation of the building, land, or equipment.

(b) When either general obligation bonds or revenue bonds issued for the benefit of the hospital to be conveyed are outstanding at the time of sale or conveyance, then the corporation and the municipality or hospital authority shall agree to the following:

By the effective date of sale or conveyance, the corporation, municipality or hospital authority shall place into an escrow fund money or direct obligations of, or obligations the principal of and interest on which, are unconditionally guaranteed by the United States of America (as approved by the Local Government Commission), the principal of and interest on which, when due and payable, will provide sufficient money to pay the principal of and the interest and redemption premium, if any, on all bonds or other debt obligations then outstanding to the maturity date or dates of these bonds or other debt obligations or to the date or dates specified for their redemption. The corporation, municipality or hospital authority shall furnish to the Local Government Commission the evidence the Commission

may require that these obligations will satisfy the requirements of this section. A hospital which has placed funds in escrow to retire outstanding general obligation bonds, revenue bonds, or other debt obligations, as provided in this section, shall not be considered a public hospital and G.S. 159-39(a)(3) shall be inapplicable to these hospitals.

(c) Any sale or conveyance under this section is subject to the following procedure:

(1) The municipality or hospital authority shall first adopt a resolution declaring its intent to sell the hospital facility at a regular meeting of the municipality or hospital authority on ten days' public notice. Notice shall be given by publication in one or more papers of general circulation in the affected area describing the intent to sell, the hospital facility to be conveyed, known potential buyers, a solicitation of additional interested buyers, and intent to negotiate the terms of sale. Specific notice, given by certified mail, shall be given to the local office of each State-supported or State-administered training, education, and treatment program in the hospital facility that has made a capital expenditure in the hospital facility, to the Department of Human Resources, and to the Office of State Budget and Management.

(2) At least 90 days prior to the proposed date of approval the municipality or hospital authority shall request proposals for purchase by:

a. direct solicitation of at least five prospective buyers; and

b. advertising in a national financial journal and in a national health journal.

The proposals shall contain the Statement of Information prescribed in subdivision (3) of this subsection and shall contain any other specifics the municipality or hospital authority considers necessary.

The municipality or hospital authority shall appoint a committee of experts in the health field and in the field of public finance to examine the proposals and to recommend to the municipality or hospital authority during the public hearing and again at the meeting on the approval of purchase which, if any, will best serve the public interest.

(3) The municipality or hospital authority shall require a Statement of Information from all proposed buyers which includes information on charges, services, and indigent care at all hospitals owned or leased in North Carolina, if any, and the most recently acquired hospitals of comparable size and similar scope located outside North Carolina in the nearest geographic proximity, not to exceed a total of five hospitals, if any. The Department of Human Resources shall develop

the Statement of Information form within 30 days of the ratification of this bill. This form shall include the following information:

a. the average total charge, for room plus ancillaries, for the five most frequent surgical procedures, using data from the most recent 12 month period available;

b. the total charge per patient day for room plus ancillaries for each of the past three years;

c. the percent of patient days for the past three years that are Medicaid days, medicare days, and indigent care days; and

d. what patient services, medical-surgical, obstetrics, pediatrics, outpatient, emergency, have been added or deleted since the purchase;

e. the percent of free care provided to individuals with incomes below the federal poverty guidelines, as compared with the gross patient revenues;

f. the percent of racial or ethnic minorities served as compared to the percent of minorities in the hospital facility's service area, as requested by the municipality or hospital authority;

g. the corporation's policy on pre-admission deposits;

h. the corporation's policy for providing emergency services to those persons unable to pay,

including the hospital facility's definition of "emergency";

i. copies provided by the corporation of the 1981 patient survey submitted to the Department of Health and Human Services, Office of Civil Rights, or a more recent report, if applicable;

j. a copy provided by the corporation of the most recent 10-K report which is submitted to the Securities and Exchange Commission, if applicable; and

k. a proposal submitted by the corporation for how it will continue to provide services to those persons with incomes below the federal poverty guidelines.

(4) At least 60 days prior to the proposed date of approval the municipality or hospital authority shall make available to the public a copy of the final proposed sale document and a Statement of Information.

(5) At least 60 days prior to the proposed date of approval the municipality or hospital authority shall notify the public of a public hearing on the proposed sale. Public notice shall be posted in the hospital facility, on the principal bulletin board of the municipality or hospital authority; and mailed or delivered to each newspaper, wire service, radio station, and TV station, and State-supported or State-administered program, which has filed a written

request for notice. This notice shall describe the hospital to be conveyed, the proposed monetary consideration or absence of consideration, the governing body's intent to authorize the sale or conveyance, and the availability of the Statement of Information.

(6) At least 15 days from the publication of the notice and at least 45 days prior to the proposed date of approval the municipality or hospital authority shall conduct the public hearing. At the public hearing the municipality or hospital authority shall hear all interested persons who appear with respect to whether the sale is in the public interest.

(7) Any sale or conveyance under this section must be approved by the municipality or hospital authority by a resolution adopted at a regular meeting of the governing body on ten days' public notice. The municipality or hospital authority shall adopt this resolution only upon a finding that the sale is in the public interest. Consideration to determine whether the sale is in the public interest shall include a consideration of whether the proposed sale will meet the health-related needs of medically underserved groups, such as low income persons, racial and ethnic minorities, and handicapped persons.

(8) The municipality or hospital authority shall require an annual report from the buyer that shows compliance with the requirements of this section.

(d) This section shall not apply to sales of surplus hospital property that is not required in the delivery of necessary hospital services at the time of sale.

(e) Neither G.S. 153A-176 nor Article 12 of Chapter 160A of the General Statutes shall apply to sales or conveyances pursuant to this section."

Sec. 4. This act shall become effective July 1, 1984 and applies only to leases, subleases, assignments, or sales made on or after this date.

APPENDIX F

S.T.: Maintanance of Health Education Facilities

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE MAINTENANCE OF HEALTH EDUCATION FACILITIES.

The General Assembly of North Carolina enacts:

Whereas, the General Assembly of North Carolina finds that is appropriated funds to the Board of Governors of The University of North Carolina and that the Board of Governors allocated these capital funds to the University of North Carolina at Chapel Hill to provide capital grants to the Area Health Education Center Program (AHEC) in order to assist in the construction of educational facilities necessary to carry out the AHEC Program; and

Whereas, the General Assembly finds that the existence of the AHEC facilities and activities remains in the public interest; and

Whereas, the General Assembly further finds it consistent with the legislative intent of its original appropriation to assure the public that the AHEC facilities and activities are maintained on an equivalent basis regardless of hospital ownership or management;

Now, therefore, the General Assembly of North Carolina enacts:

Section 1. Chapter 131E is amended by adding a new section to read:

"§131E-8.1. Maintenance of Health Education Facilities. --

(a) This section shall apply to all sales and leases of a hospital facility by a municipality or hospital authority under G.S. 131-7, -8, or -23(c) where any portion of the facility was constructed with a capital grant from the Area Health Education Centers Program (AHEC).

(b) The municipality or hospital authority shall give specific notice of intent to sell or lease and of the public hearing to the Director of the local AHEC program and the Director of the AHEC Program at the University of North Carolina School of Medicine at Chapel Hill. This notice requirement may be met by compliance with the notice requirements of G.S. 131E-7, -8, or -23(c).

(c) The municipality or hospital authority may provide continued access to the identical or equivalent facilities suitable for continuation of AHEC activities, including all services being provided under the existing operating contract. In the case of a free standing portion of the hospital facility, the municipality or hospital authority may convey all ownership rights in the facility to the local AHEC program without monetary consideration.

(d) No portion of this section shall be construed to alter rights or obligations of the operating contracts between the hospital facility and AHEC."

Sec. 2. This act shall become effective July 1, 1984.

APPENDIX G

S.T.: Ambulatory Surgical Facility

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE DEFINITION OF AN AMBULATORY SURGICAL FACILITY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E--146 and G.S. 131E-176 are amended by deleting subdivision (1) and by substituting the following:

"(1) Ambulatory Surgical Facility means a facility designed for the provision of an 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 one designated operating room 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 composed of physicians having no financial interest in the facility, and maintain adequate medical records for each patient. An ambulatory surgical facility is not a physician's or dentist's office, unless it is primarily engaged in providing an ambulatory surgical program as defined in subdivision (1a) of this section.

(1a) 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 an overnight stay is determined, prior to surgery, to be medically unnecessary."

Sec. 2. This act is effective upon ratification.

APPENDIX H

S.T.: Hospital Conflict of Interest Law

A BILL TO BE ENTITLED

AN ACT TO AMEND THE CONFLICT OF INTEREST LAW RELATING TO HOSPITALS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-21 is amended by inserting a new paragraph between the first and second to read:

"The fact that a person owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have an "interest, direct or indirect" as this phrase is used in subsections (1) and (2) of the section; provided that, in order for the exception to apply, the contract, undertaking or other transaction shall be authorized by the commissioners by specific resolution on which no commissioner or employee having an interest, direct or indirect, shall vote."

Sec. 2. This act is effective upon ratification.