AN ANALYSIS OF NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974 AND ITS IMPACT ON HEALTH CARE DELIVERY

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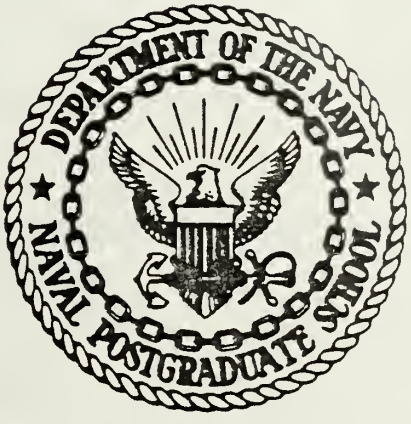

THESIS

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by

William Clare Truesdell, Jr.
Marshall Sol Duny

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I. INTRODUCTION

The health care industry is among the largest and fastest growing industries in the United States today. Expenditures for health have expanded rapidly and for the most part at a much faster rate than the rest of the economy. The private share of the medical dollar had historically been larger than the public share until the advent of such programs as Medicare and Medicaid. The shift in emphasis from private to public financing coupled with increased federal pressure toward cost containment began to impact on the industry with the implementation of Medicare. As demonstrated in Table 1, National Health Expenditures for selected fiscal years 1929 through 1974, the public's share of health expenditures had risen from 13.3 per cent in 1929 to 24.5 per cent in 1965; then to 37.3 per cent in 1968; and finally in 1974 to 39.6 per cent. Government spending for medical care had grown by more than six times from $6.4 billion in 1960 to $41.3 billion in 1974. Besides inflation it would appear that much of the increased expenditures were due to the Medicare and Medicaid programs.[1]

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[1]Page, et al. "National Health Insurance Proposals," Legislative Analysis, No. 19. American Enterprise Institute Washington, D. C. May 1973, pp 27 and 28.

Table 1.--Aggregate and per capita national health expenditures, by source of funds, and percent of gross national product, selected fiscal years, 1929-74

Fiscal year	Gross national product (in billions)	Health Expenditures								
		Total			Private			Public		
		Amount (in millions)	Per capita	Percent of GNP	Amount (In million)	Per capita	Percen of total	Amount (in millions)	Per capita	Per-Cent of total
1929	$101.0	$3,589	$29.16	3.6	$3,112	$25.28	86.7	$477	$3.88	13.3
1935	68.7	2,846	22.04	4.1	2,808	17.84	80.9	543	4.21	19.1
1940	95.1	3,863	28.83	4.1	3,081	22.99	79.8	782	5.84	20.2
1950	263.4	12,028	78.35	4.6	8,962	58.38	74.5	3,065	19.97	25.5
1955	379.7	17,330	103.76	4.6	12,909	77.29	74.5	4,421	26.46	25.5
1960	495.6	25,856	141.63	5.2	19,461	106.60	75.3	6,395	35.03	24.7
1965	655.6	38,892	197.75	5.9	29,357	149.27	75.5	9,535	48.48	24.5
1966	718,5	42,109	211.56	5.9	31,279	157.15	74.3	10,830	54.41	25.7
1967	771.4	47,879	237.93	6.2	82,057	159.30	67.0	15,823	78.63	33.0
1968	827.0	53,765	264.37	6.5	33,727	165.84	62.7	20,040	98.54	37.8
1969	899.0	60,617	295.20	6.7	37,682	183.51	62.2	22,937	111.70	37.8
1970	954.8	69,202	833.57	7.2	43,964	211.92	63.5	25,238	121.65	36.5
1971	1,013.6	77,162	368.25	7.6	48,558	231.74	62.9	28,604	136.51	37.1
1972	1,100.6	86,391	408.31	7.8	53,365	252.22	61,8	33,025	156.09	38.2
1973	1,225.2	94,235	441.94	7.7	58,415	273.95	62.0	35,819	167.98	38.0
1974[1]	1,349.8	104,239	485.86	7.7	62,929	293.01	60.4	41,310	192.35	39.6

1. Preliminary estimates. Source: Social Security Bulletin February 1975 page 5.

In fiscal year 1974 approximately $104.2 billion or 7.7 per cent of the GNP was spent for health. The increase for 1974 in total spending was 10.6 per cent, slightly higher than the revised annual increase of 9.1 per cent for 1973 when mandatory economic controls were fully in effect for the health industry. The average American spent either directly or through the government on his behalf $485 during fiscal year 1974 for health care.[2]

Several basic issues confront the health care industry in its attempts to deliver health care in an equitable and efficient manner including:

(1) Reorganization of the existing delivery system.

The impetus for reorganization of the delivery system has been attributed to the problems experienced with the Medicare and Medicaid programs. These programs were designed to relieve state and local governments of their responsibilities to provide and subsidize a basic level of health care to the aged and disadvantaged without disrupting existing patterns of health care. These programs also presented significant problems in terms of management and cost control. The problems

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[2]Worthington, Nancy L., "National Health Expenditures, 1929-74," Social Security Bulletin, February 1975, page 3.

include: (1) Duplication at the local, state and federal levels of administrative costs and (2) Bureaucratic waste and disincentives to those enrolled in the program as well as to the providers.[3]

(2) Health Manpower Maldistribution and Availability.

There exists a serious maldistribution of health manpower both by geographic location and type of physician.[4] This shortage is not a statistical shortage of physicians per capita but rather a shortage of primary care physicians and what appears to be an excess of specialists. This problem will take some time to resolve due to the long lead times required to train physicians and dentists, probably precluding any short term solutions. Moreover, the adequacy of health services depends as much upon the organization of health personnel and their combination with other resources as it does on sheer numbers alone. The problem is further complicated by the simple fact that physician manpower of all types is concentrated in the relatively prosperous urban and suburban areas resulting in shortages in both urban ghettos and rural areas.

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[3]Page, et al., pp 16-25.

[4]Stewart, Charles T., Jr., and Siddayao, Corazon M., Increasing the Supply of Medical Personnel, p. 31, American Enterprise Institute for Public Policy Research, Washington, D. C., March 1973.

(3) Cost Controls.

Health care costs continue to rise. Federal government figures show that over the past five years hospital charges have increased approximately 12 per cent per annum whereas physician's fees have increased 7 per cent per annum.[5] Although the national wage and price stabilization program did moderate this rise somewhat, it was at best temporary.

The concept of comprehensive care appears to be widely supported by those in the health care field, government officials, economists and others who are attempting to curtail the rise in costs in the delivery of health care. The problem is to develop a health care system that will, as nearly as possible, guarantee availability, accessability, continuity and quality of health care services at reasonable cost. On January 4, 1975, the National Health Planning and Resource Development Act of 1974 (hereafter referred to as the 1974 Act) was signed by President Ford. This act is an attempt to build on the federal government's past experiences in health planning to solve the previously mentioned problems and issues confronting the health care industry.

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[5]Worthington, p. 4.

The purpose of this study is to:

(1) Provide the Military Health Care Delivery System through the Navy's Bureau of Medicine and Surgery with an explanation and analysis of the 1974 Act.

(2) Attempt to determine possible changes in the methods of health planning in the civilian community as a result of the 1974 Act.

(3) Investigate potential impacts such changes may have upon the military health planning, resource development, and delivery system.

Chapter Two addresses previous federal laws and regulations pertaining to health care delivery and planning. Specifically considered are the Hospital Construction and Survey Act (Hill-Burton), the previous Comprehensive Health Planning Act (Public Law 89-749), the Professional Standards Review Organization (PSRO), and the Capital and Cost Control sections of the Social Security Act.

Chapter Three deals with the reasons given by the Congress for need for enactment of the 1974 Act. Additional investigation has been conducted to find supportive evidence for the Congressional perceptions of this need.

Chapter Four describes the administrative organization and its purpose and responsibilities as required by the Act.

Chapter Five explains the Health Services Agency, its purpose, the composition of its governing board and its functions.

Chapter Six deals with the authors' perceptions of the changes in health care planning development in the civilian sector as a result of the 1974 Act.

Chapter Seven explores the potential impact upon the Military Health Services System.

II. BACKGROUND AND HISTORY

A. BACKGROUND

Prior to the enactment of the Medicare legislation, the traditional role of government (federal, state and local) in health care had been: (1) to provide health care for the poor in the public hospital setting; (2) to provide public health services (e.g., environmental health, innoculation, health education) to the general public; (3) to subsidize medical education and education of other health professionals; (4) to subsidize hospital construction through the Hill-Burton federal program beginning in 1946; and (5) to provide quality controls through the licensing of health professionals at the state level.

The yellow fever epidemics of 1793 and 1794 led President Washington to ask congressional consent to convene the Congress away from Philadelphia because of the health hazard there. The recurrence of such epidemics led to legislation in 1796, establishing a specific though limited role for the federal government in the health field, that of quarantine enforcement.[6] Health care for citizens serving in the Army began in the early

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[6]Strickland, Stephen P., U.S. Health Care. What's Wrong and What's Right, Potomac Associates, p. 18.

days of the Republic and was extended in 1798 to all merchant seamen by the Marine Hospital Service Act. In 1799 medical care was again extended to all naval personnel.

The government began to take cognizance of the health hazards of unregulated drugs by enacting the Pure Food and Drug Act in 1906. By the 1930's, "what had been occasional grants of federal funds for medical research aimed at the conquest of disease was transformed into a permanent commitment with the establishment of the National Institutes of Health and later the National Cancer Institute."[7]

Since World War II, efforts have been made by the Federal Government to improve the delivery of health care to the American people. These new federal efforts appear to rely on the concept of a partnership with the states. For example, the use of grants to encourage hospital construction under the Hill-Burton program.

B. HOSPITAL SURVEY AND CONSTRUCTION ACT

The first major federal government intervention into the delivery of health care after World War II was the Hospital Construction Act of 1947. During the period of the depression

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[7] Ibid., p. 19.

through World War II few hospitals were built in the United States. The 1947 Report of the Commission on Hospital Care and hearings held in both houses of Congress highlighted the problems of hospital bed shortages and the unequal distribution of the existing beds among the states and between the rural and urban areas within the states.[8] In an attempt to identify and correct these deficiencies in the distribution of hospital services, the 79th Congress enacted the Hospital Survey and Construction Act (P.L. 79-725), commonly referred to as the Hill-Burton Program, in 1946. The stated purposes of this law are to assist states to: inventory their existing hospitals, survey the need for construction of hospitals, develop programs for construction of such hospitals, and construct hospitals. Congress provided funds for determining the distribution of and the need for hospital beds as well as funds to assist in the construction of needed hospitals. The need for hospital beds was to be determined by the Surgeon General of the U.S., who established an adequate level of care as a specific ratio of hospital beds to population. Once a state had documented a need for additional hospital beds, it could obtain federal funds to assist in the construction of

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[8]Lave, Judith R., and Lave, Lester B., The Hospital Construction Act, p. 7, American Enterprise Institute for Public Policy Research, 1974.

new hospitals. Priority for construction of new hospitals within a state was given to rural areas, where the need was the greatest.

The original act has been often ammended. Public Law 83-482 (1954) expanded the authorization of construction grants to include construction for outpatient facilities, long-term care facilities, and rehabilitation centers. In 1964, Public Law 88-443, funds were provided for the modernization of existing facilities. The program was expanded in 1970 to include the guarantee of construction loans by the federal government.[9] The 1970 ammendments also modified the priority of projects to receive funding. Densely populated areas and areas designated by the Secretary of the Department of Health, Education, and Welfare as poverty areas were to benefit first from the funds designated for purposes other than construction of new hospitals (i.e. funds for modernization, outpatient and long-term care facilities).[10]

Analysis of various hospital data indicates that the shortage of hospital beds has been generally eliminated.[11] Therefore, one of the goals of the Hill-Burton Program has

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[9] Ibid., p. 8.

[10] Ibid., p. 10.

[11] Ibid., p. 26.

been met. In 1970 the distribution of hospital beds across the country on a per capita basis was more nearly equal than in 1947. In 1947 the correlation of a state's per capita income to its hospital beds per capita was .62, by 1970 the correlation figure had dropped to .15.[12] In addition to reducing the bed shortages and equalizing distribution, the Hill-Burton program was one of the first efforts at state wide planning to improve the health of the public and to equalize the distribution of health services in the form of hospital beds.

C. COMPREHENSIVE HEALTH PLANNING ACT

The next major intervention by the federal government was the Comprehensive Health Planning and Public Health Services Amendment of 1966. When the Comprehensive Health Planning and Public Health Services Amendment of 1966 (P.L. 89-749)[13] was enacted its stated purpose was "...to promote and assist in the extension and improvement of comprehensive health planning and public health services to provide for a more effective use of available Federal funds for such planning and services, and for other purposes." State and

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[12] Ibid., p. 27.

[13] Hereafter this act will be referred to as the Comprehensive Health Planning Act.

regional health plans were to be developed to make health care accessible to the general population. The Congress declared that the "...fulfillment of our national purpose depends on the promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that the attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of officials and organizations; that Federal financial assistance be directed to support the marshaling of all health resources, national, State and local to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry and related healing arts."

This law gave the States a role in the nation's health activity; however, the role was mostly undefined. It paid lip service to a sort of planning role at the area-wide or metropolitan levels within the states by speaking vaguely of some sort of coordination of existing and planned health services. The law provided little additional funds to train

health planners or to stimulate experimental and demonstration health service delivery programs.

Since the law was so vague, the early administrators of the program adopted several aspects of federal policy in other legislation to provide guidance for the organization of comprehensive health planning. The area-wide comprehensive health planning agencies were to be new institutional structures, controlled by consumers (no reference had been made to the organizational pattern of such agencies in the Comprehensive Health Planning Act) broadly reflecting the total population to be served by the agency. Additionally all of the 200 or more kinds of health care providers would be given some kind of voice in the operation of such agencies as well as local government.

The lack of articulation of the goals of comprehensive health planning complicated the early administration of the federal program. There were those who interpreted the purpose of the law as the development of a broad process in which the local planning agency was simply to provide a forum in which a wide range of interest groups could exchange ideas and hopefully form a consensus on the directions to be taken to resolve the health problems of the community. "Others believed that these planning agencies were to become mechanisms

to assist in the controlling and containing of costs as well as the reorganization of the delivery of health care. Others viewed this as a threat to their prerogatives or special interests."[14]

The Department of Health, Education, and Welfare (HEW) has conducted assessments of approximately three hundred Comprehensive Health Planning Agencies in the past few years. The records of these agencies have been mixed. Some have had significant impact on the allocation and distribution of resources within their communities, while others have had little or no effect on the delivery of health services. HEW's assessments also revealed that Comprehensive Health Planning Agencies frequently encountered difficulty in completing various elements of their basic work program functions, such as: health plan development and implementation studies, public issue involvement, project reviews, agency management, community participation and education; planning coordination and data management.

Mid-Coast Comprehensive Health Planning Association articulated those weaknesses of the Comprehensive Health

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[14]Gottleib, Symond R., "A Brief History of Health Planning in the United States," p. 20, Regulating Health Facilities Construction, American Enterprise Institute for Public Policy Research, 1972.

Planning Act as follows:

> "There is general agreement that other pervasive weaknesses of Comprehensive Health Planning Agencies include: (1) the lack of a mandate or authority to regulate health facilities or institutional services; (2) inadequate training and staff development services for paid staff and volunteers; (3) the lack of sufficient resources to support the program adequately; (4) the imbalance between health planning generalist and specialist on the staff of Comprehensive Health Planning Agencies. Rural and now metropolitan agencies are having increasing difficulty in attracting specialists who have had some training and/or expertise in the areas of facility planning, manpower development, mental health or community organization; (5) the conflict, in some communities, between Comprehensive Health Planning Agencies and other federally supported programs such as Regional Medical Programs; (6) the differences in the needs, expectations, and priorities of agency staff and administrators and those of consumers. Thus some of comprehensive health planning weaknesses were structural and conceptual while others were related to the capabilities of the staff and board members of these agencies."[15]

State comprehensive health planning agencies have encountered different problems in their development. They had an even less clear-cut sense of direction about what was to be their responsibilities. Federal officials paid very little attention to them, probably stemming from the traditional reluctance (until that time) on the part of federal officials to interfere with the operation of state government.

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[15]Mid-Coast Comprehensive Health Planning Association Bid for the Establishment of a DHEW/PHS Regional Center which will provide Technical and Consultive Assistance under P.L. 93-641, p. II-2.

As a result the states were given little in the way of direction, guidance, and help in organizing their programs and developing their roles.

The law required the governor of each state to designate a single state agency to conduct comprehensive health planning, if the state was to receive any federal funds for public health services. All of the states did so, most within the first two years of the enactment of the program. However, "...there was little additional money made available for planning and since it was not really a state program, since the program's goals were unclear, and since it was not a results-oriented program of political significance, the initial compliance in most states was merely technical."[16]

In 1970 the Comprehensive Health Planning Act was renewed for another three years (P.L. 91-515) legitimizing the administration of the program by including provisions concerning the broad composition of the governing boards and advisory councils of area-wide health planning agencies. Additional funds were granted to the agencies for operations and an attempt was made to tie comprehensive health planning more

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[16]Gottleib, p. 21-22.

more closely to regional medical programs.* The program was upgraded slightly in its importance to the federal hierarchy by the establishment of the National Advisory Council on Comprehensive Health Programs to the Secretary of HEW. There had been a gradual increase in the review and comment functions assigned to the area-wide health planning agencies and to the state health planning agencies. By statute, any grants or loans requested from a Hill-Burton Agency were to be first submitted to the appropriate area health planning agency for review and comment. These reviews were not binding on the granting authority but they did carry some weight. The word was out, according to Gottleib, that a negative comment would kill the proposal.[17] Administratively HEW had been gradually increasing the number and kinds of federal grant programs in which the applicant had to first submit their proposals for review and comment.

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[17] Ibid., p. 23.

*Regional Medical programs were to provide a vehicle by which scientific knowledge about diagnosis and treatment of heart disease, cancer, stroke, and related diseases, could be transferred to providers of health care in order to improve the quality of health care to patients with those diseases.

D. PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Other recent major interventions by the federal government include the Professional Standards Review Organization section of the Social Security Act, which has as its stated purpose to assure, that the services for which payment may be made under the Social Security Act will conform to appropriate standards for the provisions of health care. Additionally the law states that payments made under the Social Security Act will be made only when the health care services had been determined to be medically necessary by the exercise of reasonable limits of professional discretion. Payment for services in hospitals would be made only if the services could not be performed on an outpatient basis or more economically as an inpatient in a different type of facility. Again this determination was to be based upon the exercise of reasonable limits of professional judgment.

A system of Professional Standards Review Organizations (PSRO's) were established through the country for determining, among other things, whether the health services for which payment is requested under the Social Security Act are, or were, medically necessary, were provided in the most economical manner (i.e. inpatient or outpatient), and that the

quality of such services met professional standards. The PSRO has the authority to determine in advance the medical necessity as well as the most economical manner of providing care in the case of elective admission to a hospital or any other health care service which requires an extended or costly treatment.

The PSRO is a non-profit professional organization whose members are licensed doctors from the area over which the PSRO exercises its authority. Thus, this law established a peer group review procedure to determine the medical necessity and the economic appropriateness of the method selected providing care.

III. CONGRESSIONAL REASONS FOR ENACTMENT OF THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

The Congress articulates the specific reasons for the enactment of the 1974 Act in the Findings and Purpose section of the law. The authors have reviewed the various Congressional Committee reports and supporting sources utilized by those committees. We feel that this review provides some insight into why Congress stated those specific needs for the 1974 Act. This chapter attempts to detail that insight.

A. EQUAL ACCESS

The first reason given by the Congress is the achievement of equal access to quality health care is a priority of the Federal Government.

As previously noted, in the preamble to the Comprehensive Health Planning Act of 1966 the Congress declared that "fulfillment of our national purpose depends upon promoting and assuring the highest level of health attainable, for every person, in an environment which contributes positively to healthful individual and family living." To obtain this goal the Congress found comprehensive planning for health services, manpower, and facilities essential. Originally

the ultimate objectives of the Comprehensive Health Planning Act were to promote the development of a healthful environment and health care system in which quality health services would be available, accessible and affordable for all persons.[18] This same goal is incorporated in the 1974 Act passed some nine years later. Why did Congress feel this goal had not been achieved?

During the early years of the Comprehensive Health Planning Act the chief executive officer of each state and territory designated a single State agency to serve as the State's Comprehensive Health Planning (CHP) agency and receive funds authorized under the Public Health Services Act. These agencies received modest Federal grants under which they were to operate. For example, in 1971 and 1972 when $7.7 million was appropriated each year, twenty-six of the fifty-six existing agencies received the minimum grant available. The Federal grant often amounted to 90 per cent of the State's effort and as many as half the State agencies each operated with a total budget of approximately $100,000 a year. Therefore, many of the agencies were small, the average State

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[18]Senate Report No. 93-1285, "National Health Planning and Development and Health Facilities Assistance Act of 1974," 12 Nov 1974, p. 9.

agency staff, including professionals and secretaries, numbering less than five people.[19]

In spite of the shortages of funds some of the States Agencies have done outstanding jobs in preparing State Health plans, implementing State certificate of need legislation, and assisting in the Economic Stabilization Program. For example, the California CHP agency established a task force with seven subcommittees composed of 357 persons who began working on a State comprehensive health plan in 1970. The participants represented consumers and providers reflecting the socioeconomic, ethnic, and geographic distribution of California's population. Meetings were held throughout the state and the resulting plan was published in 1971. This plan is still used as a guide for health professionals and State and area-wide health planners and council members throughout the State in their daily planning activities.

Many State agencies have participated in the design and implementation of statewide emergency medical services systems, the development of applications for experimental health services delivery system programs, the revisions of State medical practice and nurse practice acts to enable

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[19] Ibid., p. 9.

the use of physician assistants and nurse practitioners, a wide variety of environmental health programs, and the capital expenditures portion (section 1122) of the Social Security Act.[20]

In late 1972 and 1973 the Department of Health, Education, and Welfare (HEW) and the General Accounting Office concluded that "while the CHP program had many strengths and had in many areas made significant accomplishments, it nevertheless needed to be strengthened in a variety of ways." This conclusion recognized that many of the agencies were underfunded, understaffed, uncertain as to their direction and lacked Federal assistance and monitoring. HEW began to focus the CHP agencies on specific priority objectives to be carried out within the context of their overall comprehensive health plans. These included:

A. Minimizing uneconomic duplication of facilities and highly specialized services.

B. Fostering cost control through improved efficiency and productivity, including the promotion of cost effective preventive health care services.

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[20] Ibid., p. 9-10.

C. Fostering more effective competition within the health system in order to improve consumer choices in organizing, financing and delivery of health services.[21]

Existing health planning activities, funded under the Comprehensive Health Planning Act have been only marginally successful according to the Senate report. The fact that the performance of individual area-wide comprehensive health planning agencies were not uniformly successful has been attributed to an inadequate specific congressional mandate at the time the Comprehensive Health Planning Act was enacted, inadequate funding and inadequate authority to implement recommendations. The Senate Committee on Labor and Public Welfare (hereafter referred to as the Senate Committee) also felt that HEW had consistently failed to provide adequate resources, including technical assistance to the CHP agencies to enable them to effectively carry out their responsibilities. The Senate committee's view was "effective, comprehensive health planning activities are an absolute prerequisite to the successful implementation of a national health insurance program which will result in the provision of high quality personal health services to all Americans at reasonable costs."[22]

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[21] Ibid., p. 12.

[22] Ibid., p. 40.

From the evidence available it appears Congress feels that the concept of comprehensive health planning will assist in achieving a health care system in which quality health services would be available, accessible and affordable for all persons, i.e. a system that provides equal access to quality health care. However, the lack of funding and the resulting understaffed agencies, the inadequate specific Congressional mandate, and the inadequate authority to implement recommendations which were inherent in the Comprehensive Health Planning Act precluded the achievement of equal access to quality health care. Thus Congress has retained the goal of equal access and the concept of comprehensive planning, and has provided provisions to correct the weakness of the Comprehensive Health Planning Act in the 1974 Act.

B. INFLATION CREATED BY PREVIOUS FEDERAL FUNDING

The second reason for enactment of the 1974 Act was that previous Federal funding into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources. Congressional interest in effective health planning began with the enactment of the Hill-Burton program in 1946 which provided funds for the construction of needed new hospitals. Little change in this

Federal effort occurred until 1964 when Hill-Burton was modified by additional legislative authority for the funding of regional or area-wide voluntary health facilities planning agencies. This new authority led to the funding, in many metropolitan areas, of nonprofit private corporations governed by boards of community leaders and health care providers which sought to plan, for their whole community, the development of needed hospitals and other health care facilities.

The 89th Congress in 1965 and 1966 enacted Medicare, Medicaid and for the first time provided extensive Federal participation in health insurance.[23] This same Congress also enacted the Heart Disease, Cancer, and Stroke Amendments of 1965 (P.L. 89-239) and the Comprehensive Health Planning Act. These two acts created the Regional Medical Program (RMP) and the Comprehensive Health Planning Program (CHP). The addition of RMP and CHP to the existing Hill-Burton program meant the Federal Government was assisting States and localities in the operation of three distinct programs with different histories and responsibilities but with some overlap in their efforts and a common goal of improving the health of the American people.

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[23] Ibid., p. 5.

The Hill-Burton Hospital Construction provided over $4.4 billion in grant funds and over $2 billion in loan principal to assist in the construction and modernization of hospitals, rehabilitation facilities, and outpatient care facilities.[24] There is some evidence that Hill-Burton program had been successful in equalizing the distribution of hospital beds throughout the United States and in increasing the number of beds per capita according to the Senate Committee[25] (see Table 2).

The Senate Committee report states that "recent evidence indicates that a surplus of over 67,000 excess beds can be anticipated by 1975. The cost of supporting excess hospital beds has been estimated to be between 1 and 2 billion dollars per year, which under existing prevailing formulae for reimbursement of hospitals will continue to be paid whether or not the excess beds are occupied. Thus, empty beds contribute to the inflationary cost of medical care."[26] Additionally the "Roemer effect"* contributes to the inflationary spiral

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[24] Ibid., p. 41-42.

[25] Ibid., p. 42.

[26] Ibid., p. 42.

*Milton I. Roemer's oft quoted observation that utilization of hospital services seems always to increase to absorb excess capacity.

Table 2

Existing General Hospital Beds Per 1000 Population, 1948 and 1971

(For Highest and Lowest per Capita Income States)

	Existing Beds Per 1000 Population	
	1948	1971
High Income:		
1. Connecticut	3.90	3.71
2. New York	4.10	4.24
3. Alaska	5.99	2.32
4. Nevada	5.91	4.26
5. Illinois	3.70	4.73
6. California	3.72	3.62
7. New Jersey	3.95	3.53
8. Massachusetts	4.23	4.76
8 States	3.94	4.08
Low Income:		
43. Louisiana*	3.43	4.19
44. Kentucky*	2.47	4.35
45. Tennessee	2.43	4.64
46. West Virginia	3.67	4.61
47. South Carolina	3.01	4.04
48. Alabama	2.31	4.51
49. Arkansas	2.37	4.05
50. Mississippi	2.13	4.22
8 States	2.69	4.34

*tie
Note: Ranked by average per capita income 1967-69.
Source: Hill Burton State Plans.

by the construction of new facilities without older facilities being removed from service thereby, increasing the numbers of beds.

The Regional Medical Program (RMP) had suffered from many of the problems which had beset the comprehensive health planning agencies. Although HEW was more vigorous in implementing RMP than CHP, the RMP suffered from a lack of coordination and planning. RMP enjoyed some success and produced many identifiable accomplishments such as coronary care training and continuing education programs for practicing physicians. RMP also funded emergency medical care projects. It also suffered serious shortcomings. The successes and accomplishments relate to the structures which were established and the processes that were created. The shortcomings relate to the difficulty of finding results obtained comparable to the approximately $600 million spent during the program's history.[27]

Medicare and Medicaid were passed in 1965 to provide financial assistance for the medical needs of the elderly and of the poor. The administration of both Medicare and Medicaid programs have been criticized for their lack of

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[27] Ibid., p. 42.

coordination given the fact that these programs pay the same suppliers of services and often for services to the same patient.[28] Criticism has also been focused on administration rulings and practices that have been costly from the taxpayers' point of view. For example, prior to Medicaid many hospitals, to justify their nonprofit status, did not charge full or "reasonable" costs for welfare patients. Medicaid regulations (not the law itself) require full cost reimbursement. Additionally, Medicare mandates "reasonable cost" payments to hospitals which were paid costs plus two per cent from 1966 to 1969. This was irrespective of generally non-standardized accounting procedures, and the resulting lack of incentive for efficient operation that cost-plus pricing creates. The 1970 staff report of the Senate Finance Committee states that "under the present cost reimbursement regulations it is possible for a hospital or extended care facility to be paid costs associated with all its empty beds as well as those beds occupied by medicare beneficiaries."[29]

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[28]U.S. Congress, Senate, Committee on Finance Hearings "Medicare and Medicaid," July 1-2, 1969, p. 49.

[29]U.S. Congress, Senate, Committee on Finance, Staff Report, "Medicare and Medicaid-Problems, Issues, Alternatives," p. 52, Feb 9, 1970.

Medicare's treatment of physicians was equally generous according to the staff report which stated "Despite the legislation history - including the specific reference in the committee reports to the use of fee schedules employed by 'service benefit plans' a Social Security policy statement in 1966 maintained that 'fee schedules,' dual or otherwise, would be inappropriate to the program."[30] Largely as a result of this ruling "medicare payments are usually significantly higher than Blue Shield payments."[31]

The impact of Medicare and Medicaid is reflected in the U.S. price indices. Physicians fees over the first three years of the program rose 22% and hospital daily service charges 55%. The medical care index, which had risen at an annual rate of 4.2 per cent from 1946 to 1960 and 2.5 per cent from 1960 to 1965, jumped 6.6 per cent in 1966, 6.4 per cent in 1967, 6.2 per cent in 1968, and 6.0 per cent in 1969, with 7.3 per cent increase in physicians fees in the latter years.[32] The effect on private health insurance has been

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[30]Ibid., p. 69.

[31]Ibid., p. 61.

[32]Campbell, Rita Ricardo, "Economics of Health and Public Policy," American Enterprise Institute for Public Policy Research, Washington, D. C., Mau 1, 1973, p. 35.

to drive up premiums in relation to benefits so that premiums can cover the increasing costs of benefits.

Congressional findings indicate that although the Hill-Burton Program "equalized" the distribution of hospital beds it also created excess beds which now require funding. Additionally, other Federal programs, such as Medicare/Medicaid/RMP, have created an inflationary force upon the costs of medical care as a result of their payment procedures and policies and the effect of these policies upon rates charged to other insurers and payors. Therefore Congress has attempted, to coordinate the use of funds provided under these other acts with the health planning and resource development concepts of the 1974 Act.

C. PREVIOUS EFFORTS HAVE NOT BEEN COORDINATED

The third finding of Congress is that the many responses to the problems of equal access and inflation have not resulted in a comprehensive, rational approach to correcting: (a), the present lack of uniformly effective methods of delivering health care; (b), the existing maldistribution of health care facilities and manpower; and, (c) the increasing costs of health care. The following statement of the Senate Committee provides the background for the finding that a

coordinated planning and resource development approach is necessary - in the Congressional view - to solve the problems of equal access and inflation.

> "The need for strengthened and coordinated planning for personal health services is growing more apparent each day. In the view of the Committee the health care industry does not respond to classic market place forces. The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures.
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> "Investment in costly health resources, such as hospital beds, coronary care units or radio-isotope treatment centers is frequently made without regard to the existence of similar facilities or equipment already operating in an area. Investment in costly facilities and equipment not only results in capital accumulation, but establishes an ongoing demand for payment to support those services. There is convincing evidence from many sources that overbuilding of facilities has occurred in many areas, and that maldistribution of high cost service exists.
>
> A recently published study indicates that by 1975, over 67,000 unneeded hospital beds will be in operation throughout the United States. Hospital beds, though unused, contribute substantial additional costs to the health care industry. It is estimated that a hospital bed, full or empty, costs one third its initial cost each year to operate. Each $1,000 invested in hospital expansion requires approximately $333 each year in operational financing. This operating costs exists whether or not the bed is occupied at a particular time. The same is true with respect to medical facilities and services. A coronary care unit with a low rate of utilization, or an open heart

surgery team which performs relatively few operations a year requires a substantial proportion of the support required by similar services with a high utilization rate.

"Widespread access and distribution problems exist with respect to medical facilities and services. In many urban areas, hospitals, clinics and other medical care institutions and services are crowded into relatively tiny sectors, while large areas go poorly served or completely unserved. Many rural communities are completely without a physician or any other type of health care service, while adjacent urban areas are oversupplied."[33]

Congress apparently feels that the attainment of the equal access goal is complicated by unique economic factors affecting the health care industry and the present resource development systems which do not distribute resources uniformly or in an economically efficient manner. Again the Congressional impetus for a coordinated approach to planning and resource development to obtain the goal of equal access is apparent.

D. UNCONTROLLABLE INCREASES IN COSTS

A fourth Congressional reason or finding states that increases in the cost of health care have been uncontrollable and inflationary. According to Congress this is partially due to the lack of adequate incentives for the use of

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[33] Ibid., Senate Report No. 93-1285, p. 39.

appropriate alternative levels of care and the lack of incentives for the substitution of ambulatory or intermediate care for inpatient hospital care.

Using the information provided in Table 3, the Senate Committee states the rapid rise in the costs of personal health services have far outstripped the rate of inflation in other sectors of the economy. For example, during the April-September 1974 the CPI rise for all services less medical care rose 12.7 per cent while physician fees rose 17.4 per cent and medical care services rose 17.9 per cent. While recognizing that the increases in costs experienced by health care providers were attributable to general inflation, the Senate Committee expressed its concern with respect to the disproportionately high rate of increase in health services.

As an attempt to control the increases in the costs of health care, Congress provides funds to assist the States in administering programs for the regulation or establishment of rates for the payment or reimbursement of health services.

In the area of alternative levels of care, the Senate Committee recognized that the trend within the health care industry toward the provision of health care services, where appropriate, on an outpatient rather than an inpatient basis

Table 3

Comparison of Annual Rates of Change of the Consumer Price Index and the Medical Care Components

Item	Annualized rate of change during—						
						Post-controls periods	
	Prefreeze period, fiscal year 1969-71	Phase I, August-November	Phase II, November 1971-January 1973	Phase III, January-June 1973 [1]	Phase IV, June 1973-April 1974 [2]	Cumulative, April-September 1974	August-September 1974
CPI, all items	5.6	1.6	3.6	9.1	10.4	13.7	14.5
Less medical care	5.5	2.4	3.6	9.5	10.8	13.5	15.4
CPI, all services	7.4	3.2	3.6	4.3	8.6	13.5	14.1
Less medical care	7.4	3.6	3.4	4.3	8.6	12.7	15.1
Medical care, total	6.7	[3] —.8	3.4	3.8	7.6	16.6	12.4
Medical care services	7.6	[3] —.9	3.9	4.5	8.4	17.9	13.3
Hospital service charges [4]	NA	NA	3.6	4.0	6.2	18.7	11.8
Semiprivate room	13.0	2.8	5.4	5.2	7.1	23.4	14.2
Operating room charges	11.7	6.1	7.8	7.8	8.4	26.9	38.0
X-ray diagnostic series, upper G.I.	6.5	.8	2.8	1.3	5.3	14.0	10.5
Physical therapy [4]	NA	NA	2.9	8.6	7.0	16.0	7.3
Oxygen [4]	NA	NA	1.9	2.9	6.2	11.0	—1.1
Intravenous solution [4]	NA	NA	3.0	1.9	4.1	11.6	25.4
Electrocardiogram [4]	NA	NA	4.0	1.2	5.5	14.4	15.7
Antibiotic [4 5]	NA	NA	—.3	—5.2	3.2	7.8	—13.9
Tranquilizer [4 6]	NA	NA	2.0	6.9	3.2	2.7	—3.2
Laboratory tests (urinalysis) [4]	NA	NA	2.7	1.4	5.5	19.0	14.5
Professional services:							
Physicians' fees	7.4	2.4	2.4	4.1	6.8	17.4	13.2
General physician, office visits	8.0	1.2	2.5	3.7	8.7	18.3	14.6
General physician, house visits	6.8	6.6	3.3	3.7	3.8	17.2	15.0
Herniorrhaphy (adult)	5.9	6.1	2.4	2.8	3.8	12.3	13.6
Tonsillectomy and adenoidectomy	6.0	2.0	1.3	4.6	4.4	21.2	11.0
Obstetrical cases	6.8	2.0	2.1	6.5	5.1	16.7	10.7
Pediatric care, office visits	8.1	4.1	2.1	3.5	7.2	15.7	15.7
Psychiatrist, office visits	5.8	4.9	3.1	3.3	3.0	14.2	13.3
Other professional services:							
Dentists' fees	6.4	6.1	3.0	3.2	6.0	13.2	7.5
Examination, prescription, and dispensing of eyeglasses	5.4	3.2	2.5	6.0	5.2	11.4	8.0
Routine laboratory tests	3.8	2.0	2.6	1.6	6.7	26.1	17.5
Drugs and prescriptions	2.0	.4	0	.5	1.9	8.5	7.9
Over-the-counter items	2.8	1.2	.9	1.8	2.2	11.2	9.5
Prescriptions	1.2	—.4	—.9	—.5	1.4	6.0	5.9

[1] Refers to the voluntary controls in effect for the economy in general; for the health industry, phase II controls were continued throughout the phase III period.

[2] Refers to the controls in effect for most of the economy, which were instituted in June 1973. For the health industry, phase II controls continued throughout this period until January 1974 when new phase IV regulations went into effect.

[3] The decreases are due to the annual adjustment in the medical care index for the price of health insurance which is not shown as a component of the index but is a factor used in calculating the monthly index.

[4] January 1972=100. Phase II annualized rate of change based on percentage change since January 1972 rather than November 1971.

[5] Tetracycline hydrochloride.

[6] Chloridazepoxide hydrochloride or meprobmate.

Source: "Consumer Price Index," Bureau of Labor Statistics.

was desirable. However, it went on to state, "The trend in years past toward the inappropriate use of acute short-term hospitals for procedures which could as easily and as effectively be done on an outpatient basis, a trend fueled by prevailing health insurance reimbursement patterns, had led to the expenditure of billions of public and private dollars."[34] Apparently the Senate Committee felt that the previous unnecessary use of acute short-term hospitals had generated an excessive expenditure of funds and that incentives should be provided to encourage, where appropriate, the use of less expensive forms of care.

The incentive provided by Congress in the 1974 Act is to make available funds for developing outpatient facilities. The desire to continue the coordination of planning and resource development is apparent by the provision in the 1974 Act that outpatient facility construction will receive priority over construction of new hospitals. This is further exemplified by the requirements that not more than 20 per cent of a State's Federal allotment to be used for medical facilities projects shall be available for construction of

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[34] Ibid., p. 59.

new inpatient facilities, while at least 25 per cent of the allotment must be used for outpatient facilities that serve medically underserved populations.

Thus to counter the uncontrollable and inflationary increases in health care costs, Congress, by emphasizing the construction of outpatient facilities, hopes to encourage the use of less expensive forms of care and, by providing funds for developing rate regulation programs, hopes to control the rise in rates charged to health care payors.

E. PUBLIC EDUCATION

The fifth finding of Congress calls for the education of large segments of the public in basic knowledge regarding personal health care and in the effective use of available health services.

RMP programs began to be reoriented from high technology disease-category-oriented programs to comprehensive multi-categorical ones in 1970. By fiscal 1972, activities directed at special target populations such as Blacks, Spanish-Americans, and Indians had more than doubled, from 46 projects and $5.4 million in 1970 to 147 projects and $17 million in fiscal 1971. RMP efforts directed at improving rural areas were also expanded from 59 projects costing $3.1 million

in fiscal 1971 to 171 projects costing $10.9 million by the end of fiscal 1972.[35]

The Nation's health manpower is believed to be better trained and more qualified in a few select areas because of programs like RMP. Many new or expanded services are now more accessible as a result of programs such as supported patient care demonstration projects, manpower programs, and RMP funded start-up costs for rural health stations and free clinics.

However, Somers in 1972 stated, "Most of the nation's health problems - including automobile accidents, all forms of drug addiction including alcoholism, veneral disease, obesity, many cancers, most heart diseases, and most infant mortality are primarily attributable not to the shortcomings on the part of the providers but to the living conditions, ignorance or irresponsibility of the patient. No amount of additional funding or even reorganization of the delivery system is likely to have much impact on this problem. On the contrary, additional funds for medical care, unless

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[35] Ibid., p. 17.

accompanied by effective educational measures, could contribute to further patient irresponsibility."[36]

Studies* by a number of health economists, using multivariate statistical techniques have indicated that there is a prevasive and strong relationship between education and health status and that it is much more important than any net effect of income level on health.[37] These econometric findings on the education-health relationship find support in the recent study of health status of children from different socioeconomic backgrounds living in Washington, D.C.. The reports state that certain specific illness rates were the same regardless of economic status. However, when

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[36]Somers, Anne R., "The Nation's Health: Issues for the Future," The Annals of the American Academy of Political and Social Science, Philadelphia, Pa., Jan 1972, p. 161.

[37]Page, et al, National Health Insurance Proposals, "Legislative Analysis No. 19, American Enterprise Institute, p. 11.

*Studies cited are:
(1) Auster et al, "The Producation of Health, An Exploratory Study," in Essays in the Economics of Health and Medical Care, ed. Victor R. Fuchs, pp. 135-158.
(2) Grossman, Michael, "The Correlation Between Health and Schooling," unpublished manuscript presented at an NBER Conference on Research in Income and Wealth in Washington, D.C., 30 Nov - 1 Dec 1973.
(3) Iman, R., "The Family Provision of Children's Health," in Conference on the Role of Health Insurance, presents a multivariate statistical analysis utilizing this same data base.

children were compared by educational level of the mother, those whose mothers had more education were less likely to have iron deficiency anemia or infection related hearing-loss. These studies indicate a strong education-health relationship remains even when the amounts spent on medical care are held constant.[38]

A possible interpretation of the child health-education relation is that better educated mothers are able to detect their child's symptoms at an earlier stage. It has been suggested that poorly educated mothers should be provided with special training in order to assist them in recognizing their children's symptoms at an early stage.[39]

"Almost all the empirical studies agree that the education level of the members of a household is a more important determinant of health status than financial ability. Indeed, it may be argued that after careful examination of the data on the incidence of specific disease entities (as opposed to disability days) suggests that, except for the infant mortality, there may be no difference in health status by income levels."[40]

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[38] Ibid., p. 11.

[39] Ibid., p. 12.

[40] Ibid., p. 9.

F. PURPOSE OF THE 1974 ACT

In recognition of the problems described and the urgency placed on their solution, the 1974 Act, Section 2 (b) states, "The purpose of this Act is to facilitate the development of recommendations for national health planning policy, to augment area-wide and State planning for health services, manpower, and facilities, to authorize financial assistance for the development of resources to further that policy."

Prior to the 1974 Act no nationally applicable guidelines for health policy had existed according to the Senate Committee report. The increased Federal involvement in and responsibility for the provisions and assurance of health care services to the American people requires the promulgation of these guidelines. The 1974 Act requires the Secretary of HEW to issue such guidelines and that he "shall as he deems appropriate, by regulation revise such guidelines." The Senate Committee in its report stated, "Although the Committee wishes to reemphasize ultimate Congressional authority and responsibility for developing the basic framework for Federal health policy through legislative activity, it believes that the Executive branch has a clear responsibility to promulgate guidelines with respect to appropriate supply, distribution, and organization of health resources and with respect to

national health planning goals, taking into consideration national health priorities described in the proposed legislation." The conference report concurred with these recommendations.[41]

G. GUIDELINES FOR NATIONAL HEALTH PLANNING GOALS

Accordingly Section 1502 of the 1974 Act states "The Congress finds the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health and resource development programs:

(1) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

(2) The development of multi-institutional systems for coordination of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care and radiation therapy services).

(3) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

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[41]U.S. Congress, House Report No. 93-1640.

(4) The training and increased utilization of physician assistants, especially nurse clinicians.

(5) The development of multi-institutional arrangements for sharing of support services necessary to all health service institutions.

(6) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under Part B of title XI of the Social Security Act.

(7) The development of health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended general care) on a geographically integrated basis.

(8) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(9) The adoption of a uniform cost accounting system, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

(10) The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services."

H. SUMMARY OF CONGRESSIONAL REASONS

The overall purpose or reason for Congress' enactment of the 1974 Act appears to have been to attain the goal of equal access to quality health care. In its committee reports Congress has said that the reasons this goal has not been achieved include:

A. The lack of adequate funding, authority, and direction provided in the Comprehensive Health Planning Act.

B. Inflation created by the various previous, uncoordinated Federal programs to improve health care.

C. Uncontrollable and inflationary rises in the cost of health care due to a lack of adequate incentives to use less expensive forms of care and the lack of rate regulation.

D. Present resource distribution systems have not resulted in a uniform distribution of resources.

The 1974 Act hopes to obtain the goal of equal access through the use of a health care planning and resource development system that functions at the federal, state and

local levels. Congress has provided in the 1974 Act what it believes is an adequate level of funding, adequate direction and guidance, and adequate authority to provide a system of comprehensive, integrated health planning and resource development agencies which will be capable of solving the previous problems which have prevented the attainment of equal access to quality health care.

IV. ORGANIZATION FOR ADMINISTRATION OF THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974[42]

A. GENERAL DESCRIPTION

The provisions of the National Health Planning and Resources Development Act of 1974 (1974 Act) will be implemented and administered through organizations established at the federal, state and local level. These organizations are the Secretary of HEW (Secretary), the National Council on Health Planning and Development (National Council), the State Health Planning and Development Agencies (State Agencies), the Statewide Health Coordinating Councils (State Council), and the local Health Systems Agencies (HSA). This chapter will discuss the functions, purpose and composition of the national and state level organizations; Health Systems Agencies will be described in detail in the following chapter. Additionally, the organization within HEW, which will administer the 1974 Act is discussed and the State Administrative Program is described.

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[42]The primary source of information from which this chapter has been derived is Public Law 93-641.

Briefly, the Secretary of HEW is charged with the overall administration and implementation of the 1974 Act. The Secretary will make agreements establishing the state and local agencies as well as issue the rules and regulations under which health planning and development is to be conducted. The National Council on Health Planning and Resource Development will advise and assist the Secretary in establishing national guidelines and policy. State Health Planning and Development Agencies will conduct the health planning activities of the state, prepare a preliminary state health plan, and implement the state health plan. The Statewide Health Coordinating Council will prepare the state health plan using the preliminary plan as a guide, coordinate the plans of the Health Systems Agencies and review health planning activities conducted within the state. The local Health Systems Agencies will develop local health plans and implement those plans. Chart 1 provides an organizational display of these agencies.

B. SECRETARY OF HEW

The Secretary of HEW is the senior member of the organization established to implement the 1974 Act. The duties of the Secretary are many and varied. They include development of national guidelines, issuance of regulations, review and

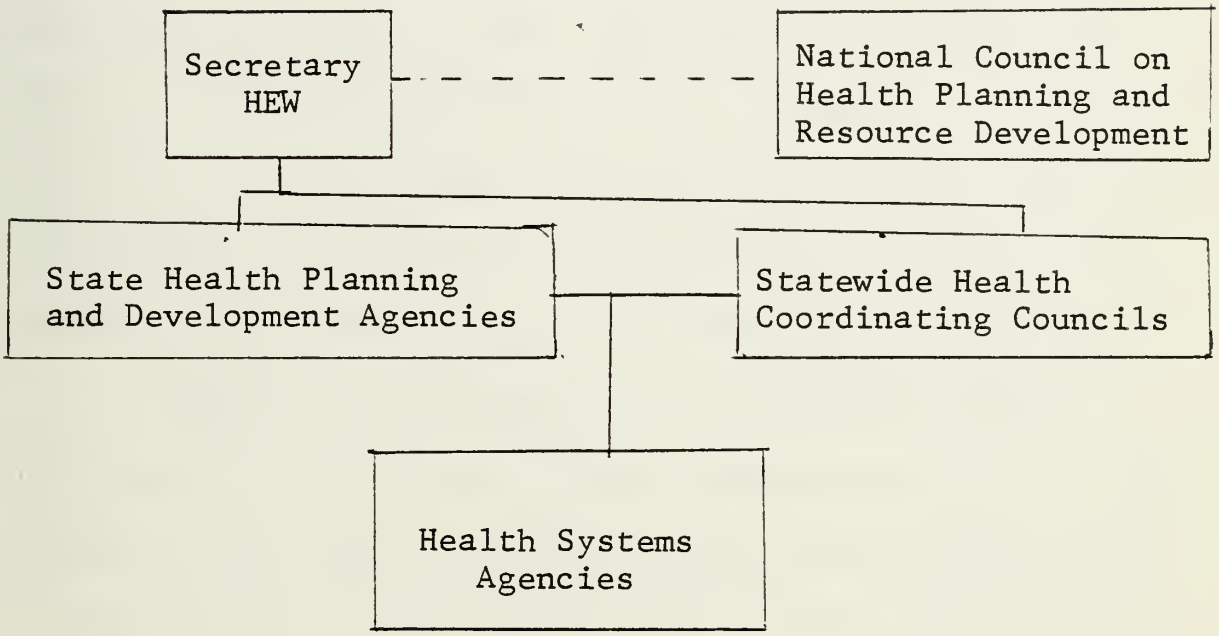
approval or disapproval responsibility, authority to designate agencies, granting of funds, and establishment of organizations and systems to improve planning. Appendix A provides a detailed listing of these duties and responsibilities. Some of the more important duties are presented here.

1. National Guidelines

The cornerstone for implementing the 1974 Act will be the guidelines concerning national health planning policy. The Secretary is to issue these guidelines. Although the guidelines have not yet been issued (issuance is due not later than July 1976, according to Section 1501 of the Act), the 1974 Act requires the Secretary to include: a) standards respecting the appropriate supply, distribution and organization of health resources; and b) a statement of national health planning goals, expressed to the maximum extent practicable in quantitative terms. The Secretary's authority to establish these guidelines and goals provides him with considerable ability to determine the impact of the 1974 Act upon health planning and development.

Chart 1

National Health Planning and
Resource Development Organization



2. Issuance of Regulations

The Secretary of HEW has the authority to, or in some cases the responsibility of, issuing regulations which will implement the provisions of the 1974 Act. These regulations, which are to be published in the Federal Register, will carry the force of law. The issuance of regulations alone provides considerable authority; however, the subject matter of the regulations that the Secretary will issue gives him expanded authority in the sense that the subject matter shapes and regulates the type of health planning performed.

Regulations applying to Health Systems Agencies will cover areas such as: a) the standards and criteria pertaining to the legal structure and functions of the agency; b) specification of the minimum data needed to determine the health status of the residents, the status of health resources and services and the determinants of such status; and c) the planning approaches, methodologies, policies and standards to be used for appropriate planning and development of health resources. Regulations to be issued affecting State Agencies include areas such as: a) procedures for the evaluation of the performance of State Agencies; b) prescribing performance standards covering the structure, operation and performance of functions of State Agencies; and c) prescribing the manner

in which each State Agency shall determine the priority among projects for which Federal financial assistance is available. Other regulations will prescribe the criteria for determining the need for medical beds and facilities and for developing plans for distributing these beds and facilities. The regulations, most of which have yet to be issued, will have an impact upon planning and resource development.

3. Review and Approval/Disapproval Functions

The Secretary will be reviewing and approving or disapproving many plans and requests for funds as well as intended uses of funds. Reviews will be conducted to determine: a) the ability of state and local agencies to fulfill the requirements of such agencies; b) the structure, operation and performance of the agencies; c) the sufficiency of the information contained in State Administrative Programs; and d) the size and qualifications of required personnel serving on the staffs of State Agencies. The Secretary will be reviewing and approving the annual budgets of State Agencies and HSAs. The reviewing and approving responsibilities give the Secretary the ability to monitor implementation of the 1974 Act and to ensure compliance with the regulations he has issued.

4. Designation Responsibility

The Secretary will be making agreements designating the State Health Planning Agencies and the Health Systems Agencies. Once he has designated such agencies, he will, through the review functions, be making decisions to terminate or renew designations. Again the "power" of the Secretary is apparent as a result of his ability to terminate or refuse to renew agreements with agencies which do not comply with his regulations.

5. Granting of Funds

The Secretary will be granting funds to state and local agencies to provide for their operations, to assist in developing plans and to demonstrate the effectiveness of rate regulation programs. Additionally the Secretary may withhold payments from allotments made to States if the States fail to comply with provisions required by the 1974 Act. Thus the Secretary has a "hammer" with his ability to issue or not issue funds to the States. This "hammer" is very large when it is realized that the sole source of Federal funds to conduct health planning activities is now provided through provisions of the 1974 Act. Planning funds previously available from the Comprehensive Health Planning Act are being terminated. Additionally, Federal funds for construction

and modernization (Hill-Burton) and funds provided through the Regional Medical Program will be administered through provisions of the 1974 Act.

6. Other Functions

Other functions of the Secretary include the establishment of a national health planning and information center to support the planning and development programs of the state and local agencies. The Secretary is to establish uniform systems for: cost accounting; calculating the volume of services; for calculating the rates to be charged to health insurers; and for reporting costs, volume of services, and rates charged by health service institutions.

The Secretary has considerable authority as a result of his ability to issue guidelines and regulations, to review and approve plans, review and approve uses of/or requests for funds, to designate and re-designate agencies, and to grant funds. The exercise of this authority and the performance of the associated functions will be performed by an organization within the Department of Health, Education and Welfare.

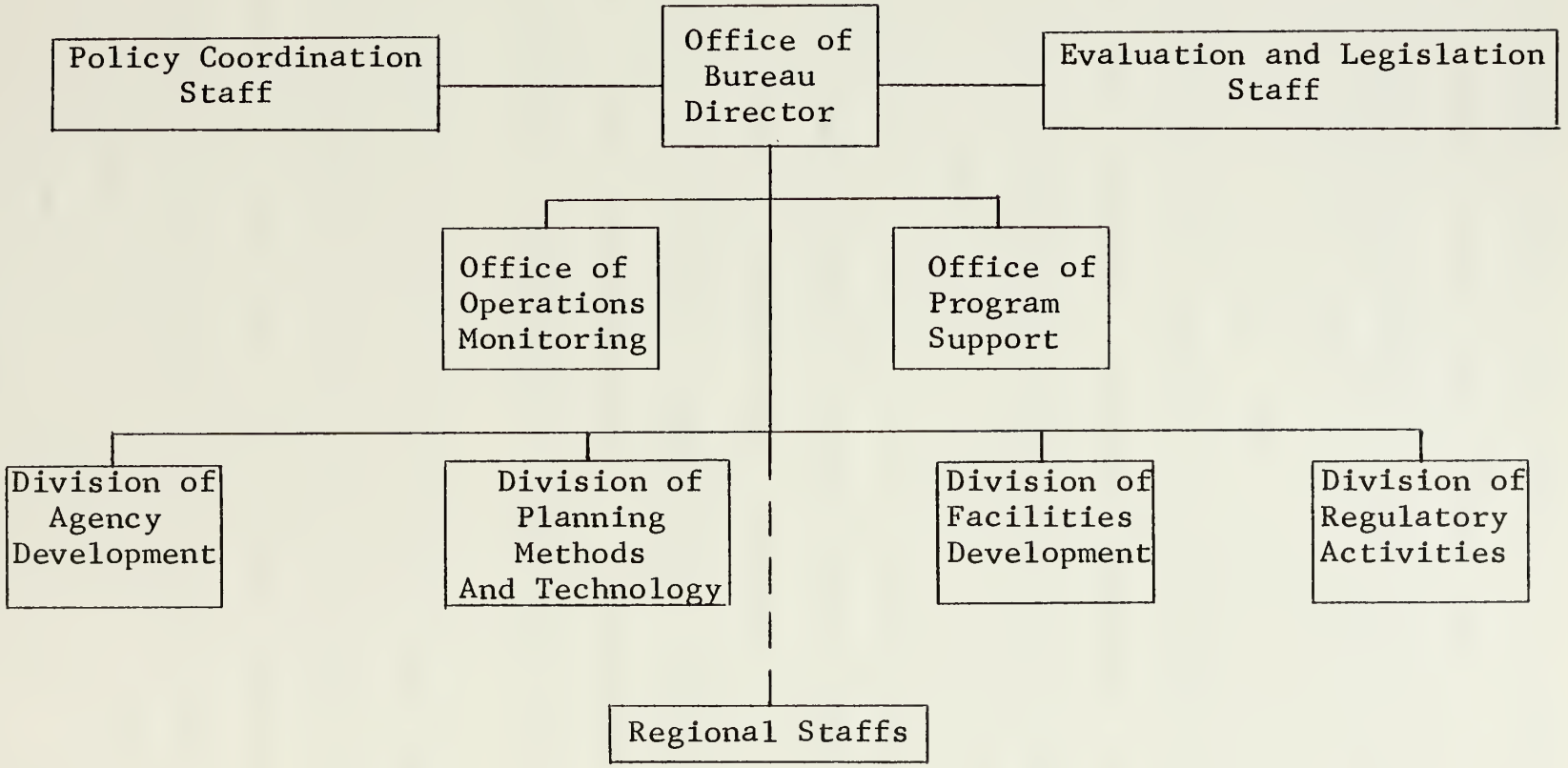
C. BUREAU OF HEALTH RESOURCES PLANNING

The organization which is to act on behalf of the Secretary of HEW is the newly formed Bureau of Health Resources Planing. This Bureau was created after the passage of the 1974 Act in January 1975, and a limited amount of information is presently available on this Bureau. The majority of information available to the authors was provided by Ms. Gale Held, Regional Program Consultant, Health Planning Branch of the San Francisco Regional Office of HEW. An organizational diagram of the Bureau of Health Resources Planning is provided in Chart 2.

According to the information provided by Ms. Held, the Bureau serves as the principle focus within HEW for the national leadership and administration of an improved program of Federal, State and area-wide health planning and delivery systems development. The Policy coordination staff serves as the focus for bureau-wide policy coordination. The Evaluation and Legislation Staff serves as the Director's source of advice on program evaluation and legislative affairs. The Office of Operations Monitoring provides a focal point for coordinating and monitoring the operational activities carried out at the regional office level (these activities are significant, as will be shown later). The Office of

Chart 2

Bureau of Health Resources Planning



Program Support plans, directs and evaluates the administrative management support activities of the Bureau by providing or acquiring services and resources in the requisite management areas. The Divisions serve as focal points for Bureau activities in each of the areas. The Division of Planning Methods and Technology will develop and disseminate the necessary technical materials, planning approaches, methodologies, policies, standards and guidelines for the appropriate planning of health resources and services. The Division of Agency Development is to provide for the operational and management development of Health Systems Agencies and State Agencies. The Division of Facilities Development is to provide standards to be used in construction, modernization and expansion of health care facilities. The Division of Regulatory Activities coordinates the regulatory activities of the Bureau.

From the limited descriptions of functions that were available from discussions with Ms. Held, it appears that the Divisions will be developing the national health guidelines and creating the regulations which the Secretary will issue. All criteria and standards to be used in implementing the 1974 Act will be generated at the Bureau level. The Regional Staffs will be performing the majority of the

Secretary's review and approval functions. The Regional Staffs will be entering into agreements designating State Agencies and Health Systems Agencies and making grants to those agencies. The Bureau level, Office of Operations Monitoring will be coordinating the activities of the Regional Staffs and ensuring their compliance with provisions established by the regulations. Ms. Held, states there are billets for approximately 150 professionals at the Bureau level and five to ten professionals at each of the nine Regional Staffs. The Regional Staffs will be organized similar to the Bureau level divisions (i.e., an agency development billet, a regulatory billet, etc.). Thus there appears to be a centralized organization for developing guidelines and regulations and a decentralized organization to implement those guidelines and regulations.

D. NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

The Secretary will be assisted in the performance of his duties by the National Council on Health Planning and Development (National Council). The National Council will advise, consult and make recommendations to the Secretary with respect to: the development of national guidelines, the implementation and administration of the act, and evaluations

of the implementation of new medical technology. The evaluations of the implementation of new medical technology is to include evaluations of changes in the organization, delivery and distribution of health care services.

The composition of the membership of the National Council is specifically detailed in the act; although, the Secretary is to appoint the members to the council. The fifteen voting members of the council must be selected from the following groups: not less than five members shall be persons who are not providers of health services; not more than three members shall be employees or officers of the Federal Government; not less than three members shall be members of health systems agencies; and finally, not less than three shall be members of Statewide Health Coordinating Councils, one of the two state level agencies. Additionally these voting members must be chosen so that the two major political parties will have equal representation. The terms of office of the voting members are six years, with expiration dates staggered so as to provide continuity. In addition to the voting members there are three non-voting exofficio members: the Chief Medical Director of the Veterans Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary of Health of HEW

E. STATE LEVEL ORGANIZATIONS

The 1974 Act provides for the establishment of two state level organizations, the State Health Planning and Development Agency (State Agency) and the Statewide Health Coordinating Council (State Council). The State Agency is to conduct the health planning activities of the State and to implement those parts of the State health plan which relate to the government of the State. The State Council is to coordinate the plans of the Health Systems Agencies, conduct reviews of requests for funding grants and review the budgets of HSAs. The State Council will also develop the State Health Plan after considering the plans of the HSAs and the preliminary State health plan developed by the State Agency.

1. State Health Planning and Development Agencies

The governor of each State is to select the agency which will be designated by the Secretary as the State Health Planning and Development Agency (Stage Agency). However, before a State Agency may be designated, the Secretary has to approve a State Administrative Program which has been submitted by the State.

a. State Administrative Program

The State Administrative Program is a plan for the performance of the functions of a State Agency. Appendix

B contains a detailed listing of the requirements of a State Administrative Program. The overall purpose of the program is to assure the Secretary that the State Agency will have the authority to perform the functions required by the 1974 Act. The State Administrative Program must provide that the State Agency is the sole organization which will be performing these functions and that State law provides the authority for the State Agency to carry out its functions. The State Administrative Program must provide for an appeals mechanism consistent with State law in the event the State Agency makes a decision pertaining to Certificate of Need procedures which is inconsistent with the recommendation of a Health Systems Agency.

b. Designation of a State Agency

Once a State Administrative Program has been approved the Secretary may designate the State Agency. To provide for an orderly implementation of the provisions of the 1974 Act, two forms of State Agency designations may be made--a conditional designation or a full designation.

A conditional agreement is made for the purpose of determining the capacity of the designated State Agency to administer the state administrative program and to carry out the health planning and development functions of a State

Agency. When a conditional agreement is made, the governor must provide the Secretary with a plan for the orderly assumption and implementation, by the conditionally designated agency, of the functions required of a State Agency. The period of a conditional designation may not exceed twenty-four months.

If, on the basis of an application for designation as a State Agency or on the basis of performance of a conditionally designated agency, the Secretary determines that the agency is capable of fulfilling the responsibilities of a State Agency, he may make a full designation agreement with the governor. An additional requirement exists for a full designation. This requirement calls for the establishment of a Statewide Health Coordinating Council (to be discussed later). An agreement for a full designation is to be made for a term not to exceed twelve months. These agreements may be renewed by the Secretary for twelve month periods if the Secretary has determined that the State Agency has performed its functions in a satisfactory manner.

c. State Agency Functions

The overall function of a State Agency is to conduct the health planning activities of the state including administration of the state certificate of need program,

preparation of a preliminary State Plan to be submitted to the Statewide Health Coordinating Council, preparation of a state medical facilities plan to be approved by the Statewide Health Coordinating Council, making findings as to the need for new institutional health services within the state and reviewing all institutional health services being offered within the state. Appendix C contains a listing of the functions of the State Agency. The State Agency performs the functions of an implementing organization for health care planning, development, and delivery within its state.

2. Statewide Health Coordinating Council

Just as the Secretary is to be advised by the National Council, the State Agency will be advised by the Statewide Health Coordinating Council (State Council). In addition to its advisory role the State Council will review and coordinate the health plans of the local Health Systems Agencies, prepare the State Health Plan, review the budgets of the Health Systems Agencies, review applications for grants, and advise the State Agency on the performance of its functions. Appendix D provides a listing of the State Council's functions. The State Council reports the results of its reviews to the Secretary. Thus there is a State Agency which implements the plans for health planning and development and a State

Council which approves those plans as well as reviews and reports to the Secretary on the use of funds.

The members of the State Council are appointed by the governor of the state. These appointments must come from two categories of persons. The first category are nominees submitted by the Health Systems Agencies of the state. Each Health Systems Agency is to submit a list of at least five nominees. The governor is to appoint at least sixteen people from these lists with the following conditions. Each Health Systems Agency is to have at least two representatives and each Health Systems Agency shall have the same number of representatives and not less than one-half of these representatives shall be consumers of health care who are not also providers. The other category is appointments the governor has deemed to be appropriate. The number of these "appropriate" appointments may not exceed forty per cent of the council and a majority must be persons who are consumers of health but not also providers. One additional requirement is that not less than one-third of the members who are providers of health care shall be direct providers. If there are two or more Veterans Administration Hospitals or health care facilities within the state, the State Council shall include an ex officio non-voting member designated by the Chief Medical Director of the Veterans Administration.

F. SUMMARY OF FEDERAL AND STATE ORGANIZATIONS

Four separate but coordinated organizations have been established to implement health planning and resources development at the national and state levels. The Secretary of HEW appears from the duties and functions described in the 1974 Act, to be the dominant organization. The National Council on Health Planning and Development, which is made up of representatives of the State Council, the local Health Systems Agencies, consumers of health care and the federal government, will advise and made recommendations to the Secretary on the development of health guidelines and the implementation of the law. A Statewide Health Coordinating Council, made up of representatives of the local Health Systems Agencies, providers and consumers of health care and the state government, will develop state health plans and review for the Secretary the use of federal funds. The State Health Planning and Development Agencies will conduct the health planning activities and implement the health plan.

V. HEALTH SYSTEMS AGENCIES[43]

To provide for effective health care planning and resource development at the local level, the 1974 Act requires the designation of some 200 health service areas throughout the country and the establishment of a Health Systems Agency (HSA) to administer and implement the law in each of the health service areas. This chapter will discuss the administrative procedures for designating health service areas, the requirements such areas must meet, procedures for establishing Health Systems Agencies, and the functions of those agencies.

A. HEALTH SERVICE AREAS

The governor of each state is to divide his state into health services areas and submit to the Secretary a listing and description of the designated health service areas. The

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[43]Sources of information used in this chapter are:

1. National Health Planning and Resources Development Act of 1974, Statutes at Large, Part B.
2. U.S. Department of Health, Education and Welfare, "Health Systems Agencies," Federal Register, Vol. 40, No. 202, Oct 17, 1975.
3. U.S. Department of Health, Education and Welfare, "Health Systems Agencies," Federal Register, Vol. 41, No. 60, March 26, 1976.

Secretary is to accept the governors' designation unless the areas do not meet the requirements of the law.

To meet the requirements of the law each area must fulfill the following conditions. The area selected must be appropriate for effective planning and development of health resources. To the maximum extent feasible the boundaries of the area must coincide with the boundaries of areas established for the Professional Standards Review Organizations. The population of the area, with certain exceptions, must be between 500,000 and 3,000,000. To the extent practicable the area must contain at least one center for the provision of highly specialized health services. The area shall be selected so as to recognize the differences in health planning and services development between metropolitan and nonmetropolitan areas. Unless the Secretary approves otherwise, each standard metropolitan statistical area shall be entirely within the boundaries of one health services area, thus the boundaries of a health service area may include portions of several states.

If any area of the United States is not included in one of the areas designated by the governors as health service areas, the Secretary shall establish a health service area for that area. In establishing these health service areas

the Secretary may modify the areas designated by the governors. Additionally the Secretary may modify the health service areas designated by the governors if, upon the basis of his review, the Secretary determines the areas do not meet the requirements of the law.

B. ORGANIZATION OF HEALTH SYSTEMS AGENCIES

Each health service area shall have a Health Systems Agency which shall have as its primary responsibility the provision of effective health planning for the area and the promotion of the development within the area, of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies and implement the plans of the agency. To be designated as a Health Systems Agency an organization must meet certain requirements pertaining to legal structure and organization.

1. Legal Structure

There are three different legal forms of organization an HSA may assume. It may be a nonprofit private corporation or similar legal mechanism such as a public benefit corporation, which is incorporated in the state in which the largest portion of the population of its health service area resides. Such a corporation may not be a subsidiary of or be controlled by any other private or public corporation or other legal

entity. Additionally, such a corporation must be authorized to engage only in health planning and development functions.

The second legal form an HSA may assume is that of a single or multipurpose regional planning body. If this form is chosen the area of the planning body must be identical to the health service area. Additionally, the planning body must have a governing board composed of a majority of elected officials of units of general local government or have been in existence prior to January 4, 1975, and authorized by state law to carry out the health planning and review functions required of an HSA. However, the planning body must not be an agency of the state government.

The third organizational form is that of a single unit of general local government, if its area of jurisdiction is identical to that of the health service area. Regardless of the legal form of organization, an HSA may not be or operate an educational institution.

Each Health Systems Agency, regardless of legal form, is to have a staff which provides the agency with expertise in at least the following areas: (1) administration, (2) the gathering and analysis of data, (3) health planning and (4) development and use of resources. The planning and development functions are to have separate staffs with skills

appropriate to each function. The minimum size of the staff is determined by size of the population of the health service area but in no case will a staff consist of less than five people.

2. Governing Body

Each Health Systems Agency, regardless of legal form, is to have a governing body. The responsibilities of the governing body, generally speaking, are to have the exclusive authority to perform for the agency the functions of the HSA and to assume the responsibility for all actions of the HSA when the agency makes a review, approval or disapproval of a plan, program, grant or use of funds. The governing body is also responsible for the establishment of the health systems plan and the annual implementation plan (both to be discussed later). Appendix E contains a detailed listing of the responsibilities of a governing body.

The governing board of an HSA which is a public regional planning body may establish rules and regulations for the exercise of the responsibilities of a governing body. The governing board of such an organization is not to be confused with the governing body of the organization. The governing board is normally composed of elected officials who are members of the HSA. The governing body performs an

"overseeing" function for the HSA. As pointed out by the Secretary in the Federal Register, problems exist when the governing board (elected officials) is to be "overseen" by a governing body. The problems are further complicated when the governing board (elected officials) can establish rules and regulations for exercising the responsibilities of the "overseeing" governing board. In short, who "oversees" whom? The Secretary recognizes this problem and feels it will engender disabling conflict. The Secretary intends to write a letter to Congress expressing his concern and stating he would support a legislative amendment to remove this conflict.

A majority, but not more than sixty per cent, of the members of the governing body shall be residents of the health service area who are consumers, and not providers, of health care. These members must be broadly representative of social, economic, linguistic and racial populations. They must also represent geographical areas and major purchasers of health care. The remainder of the members must be residents who are providers of health care. The total membership must include a number of public elected officials. If there are one or more VA Hospitals located within the health service area, the Chief Medical Director of the VA

shall designate a person who will be a non-voting ex officio member of the governing body. If a health maintenance organization services the health service area, the governing body is to include a representative of such an organization. There are to be between ten and thirty members of the governing body.

3. Purpose and Responsibility of the HSA

For the purposes of (1) improving the health of the residents of a health service area, (2) increasing the accessability, acceptability, continuity and quality of health services, (3) restraining increases in the cost of providing care, and (4) preventing unnecessary duplication of health resources each HSA shall have as its primary responsibility (1) provision of effective health planning for its area, (2) the promotion of the development of within the area of health services, manpower, and facilities which meet identified needs and reduce documented inefficiencies, and (3) implement the health plans of the agency.

4. Functions of the HSA

In carrying out its primary responsibility an HSA has certain specific functions to perform. Appendix F provides a detailed listing of these functions. Only functions the authors believe to be the more important will be described here.

The first function of an agency is to collect and analyze data concerning the status of the health of its residents, status of the health resources, and the patterns of utilization of the resources. The information obtained from the analysis of this data will be vital to the performance of many of the other functions of the HSA. The Secretary is to specify the minimum data necessary to perform this function. He has yet to do so.

Two other functions of an HSA are particularly significant as they impact upon the functions and plans of the State Agency. These functions require the HSA to establish, review annually, and amend as necessary, a health systems plan (HSP) and an annual implementation plan (AIP). After consideration of the national guidelines for health planning, which have not yet been issued by the Secretary, the HSA is to establish a health systems plan which is to be a detailed statement of the goals describing a healthful environment and health systems which, when developed, will assure that quality health services will be available for all residents of the health services area. The goals of the HSP are to be responsive to the unique needs and resources of the area as determined by the data collection and analysis functions.

Once the HSP has been established the HSA is then to establish an Annual Implementation Plan (AIP). The AIP is a statement of the objectives that will achieve the goals of the HSP. The AIP must also list the priorities among the objectives. In establishing the objectives of the AIP the agency must give priority to objectives which maximally improve the health of the residents. This is to be determined on the basis of the relation of the cost of the objective to its benefits. Specific plans and projects must be developed for achieving the objectives of the AIP.

The HSP and AIP became the standards against which all additions to, changes in or reviews of health resources must be measured. All plans for changes in the health resources of an area must be consistent with the HSP and AIP. The HSP and AIP are to be used by the State Agency and State Council in developing the State Plan. Additionally in reviewing applications for grants and other funding, HSAs, State Councils and the Secretary must determine that these funds will be used to achieve the goals of the HSP and AIP.

Another important function given to an HSA by the law is the ability to review and approve or disapprove the use of federal funds granted by the act and several other acts, within its health service area.

This approval/disapproval authority did not formally exist for the CHP Agencies under the previous act. However, the ability to disapprove the use of federal funds is weakened by the Secretary's ability to override such a decision after considering the comments of the respective State Agency.

Health Systems Agencies are also to review and make recommendations to the State Agency concerning the appropriateness of existing institutional health resources. These recommendations are to be used by the State Agency in making its findings concerning the appropriateness of existing institutional health services. Appendix G provides a listing of procedures and criteria to be used when conducting reviews.

Each HSA shall annually recommend, to the state agency, projects for modernization, construction and conversion of medical facilities in the agency's health service area. Projects must be prioritized and agree with the HSP and AIP of the HSA.

Perhaps as important as reviewing and making recommendations concerning existing medical facilities and services each HSA will now review and make recommendations concerning the need for new institutional health services proposed to be offered or developed in the health service area.

C. DESIGNATION OF HEALTH SYSTEMS AGENCIES

Health Systems Agencies are to be designated in a manner similar to that of the designation of State Agencies. Applications must be submitted through state governors. The application must meet such requirements for information pertaining to organization, staffs, plans, functions and duties as the Secretary may require. The Secretary may make a conditional designation for the purpose of determining the agencies ability to perform the functions of an HSA. A conditional designation may not be for a period exceeding twenty-four months. If the Secretary determines on the basis of the application or the performance of a conditionally designated agency, that an agency is capable of performing all the functions of an HSA, he may make a full designation. Such a designation shall be for a period not exceeding twelve months. The Secretary may renew designations for periods of twelve months based upon his review of the performace of the agency; except, that a conditionally designated agency may not remain so designated for more than twelve months.

The Health Systems Agency is to implement the law at the local level. It is the organization through which the community becomes involved. Through this organization the

goals and objectives of health care planning and resource development from the federal level to the local level will be performed. Although many of the activities of the HSA will be controlled by actions of the Secretary it is the organization that the public will identify as its health planner and developer and thus the performance of the HSA may determine the success of the objectives of the act.

VI. CHANGES IN HEALTH CARE PLANNING AND DEVELOPMENT AS A RESULT OF THE NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

The National Health Planning and Resource Development Act of 1974 was enacted by Congress and signed by the President in an attempt to provide the mechanism for achieving specific goals in the area of national health care. The purpose of this chapter is not to speculate as to whether or not the 1974 Act will assist in attaining these goals; rather, it is to suggest what we believe will be major changes in health care planning and resource development as a result of the 1974 Act.

A. FEDERAL INVOLVEMENT

The primary change appears to be in the degree of involvement of the Federal Government in health care planning and development. Under the Comprehensive Health Planning Act, Federal involvement was limited. This lack of Federal monitoring and assistance was identified as one of the weaknesses of the Comprehensive Health Planning Act. Additional evidence of this Federal non-involvement is apparent in the preamble to the Medicare Act where Congress declared

that Federal officials would have no authority to intervene in the practice of medicine or in the administration of health facilities. As stated by Mr. Eugene W. Rubel, former Director of the Bureau of Health Planning and Resource Development, Federal non-involvement has been terminated.

> "We are now very definitely intervening in the private practice of medicine and in the organization and operation of health care institutions and the primary reason is dollars. More and more of the federal budget is going toward health care expenditures. As inflation has eaten up all of the benefits of Medicare, there's been an overwhelming need to say that the government can no longer play the passive role of simply paying the bills."[44]

The form and extent of this Federal involvement is discerned from the duties and functions of the Secretary of HEW. The Secretary will determine the basic guidelines of the national health planning policy which are to be used by all planning organizations. The Secretary will specify the data to be used in determining the health status and health needs of the population as well as the status of the health resources. The Secretary will prescribe the manner in which priorities will be established among facilities projects. Federal officials will be reviewing and approving or disapproving the performance, plans and budgets of the various

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[44]As quoted by Gregg W. Downey, "Healthcare Planning Gets Muscles," Modern Healthcare, March 1975, p. 32.

planning organizations. The adequacy of each State's Certificate of Need legislation will be determined by the Federal government.

The Federal government will be guiding, reviewing and approving, in a sense controlling, the health planning of the nation through its influence over the State and local agencies. The ability to use this influence is made possible through control of Federal funds. If a State Agency or an HSA is not performing in a manner acceptable to the Secretary, the designation agreement may be terminated or not renewed by the Secretary. Without a designated agency, grants to be used for health planning are terminated. Funds available for planning under the 1974 Act are significantly larger than were available under the Comprehensive Health Planning Act. The lack of these Federal funds would adversely affect the resources available to an agency and hence its ability to function.

A more specific example of the Federal government's ability to intervene is in the area of the Certificate of Need program. The 1974 Act does not require a State to enact Certificate of Need Legislation (CON). However, if a State fails to enact a CON program by 1980, no one in the State is eligible to receive any federal funds under the Public

Health Service Act. This has the effect of forcing States to enact a CON program. Further each State's CON program must be acceptable to the Secretary.

The Secretary will be providing the funds which an HSA will use to conduct its operations and pay its staff. The Secretary will also be reviewing the performance of the HSA. Since the staff of the HSA, regardless of its organizational form, will be receiving the majority of their salaries from federal funds, there will be an incentive to comply with the directions and guidance of the Secretary or, at least, not to deliberately ignore the Secretary. Because, if the Secretary feels the HSA's performance is unsatisfactory, he can terminate the HSA's designation and the staff would be in a sense unemployed.

It is unlikely that the entire flow of federal funds to a State would be terminated. But it is likely that funds would be selectively withheld or delayed if a State or HSA was deliberately ignoring provisions of the 1974 Act.

Federal involvement is probably going to be in the form of guiding, directing and controlling the planning effort and ensuring through the review procedure that resource development is taking place in accordance with the plans that have been developed. The denial of funds is probably

more of a threat than it is a reality; however, the threat should do a great deal to encourage cooperation.

B. CERTIFICATE OF NEED

As mentioned earlier, States will be enacting CON programs. Although the concept of CON is not new, the 1974 Act will create changes to previous CON programs. First, CON is in actuality, if not legally, mandatory for all States.

Second, the requirements of a CON program are going to be determined by the Secretary. As yet these requirements are unknown; however, they will probably cause all existing CON programs to be modified. This is exemplified in the following statement by Mr. Rubel.

> "I think every single certificate-of-need program now in existence will have to be changed as a result of this law. It's entirely up to us to determine what will be required, and all of the present programs are going to be found wanting in one way or another."[45]

Thirdly, under provisions of the 1974 Act, before any facility can be constructed or before any significant amount of money may be expended for facility construction, it must be demonstrated that the facility fulfills the CON requirements. Previously the operators of a newly constructed

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[45] Ibid., p. 33.

facility could apply for funding assistance through the CON and Hill-Burton program after the facility was constructed. If the facility failed to meet CON requirements, it did not receive funding assistance; however, the facility existed even though it was not needed. Thus under previous CON programs it was possible to expend resources (although not federal funds) on a facility that was not required. Once built this unnecessary facility could continue to command resources through the Roemer effect. The 1974 Act says that unnecessary facilities will not be built in the first place.

Additionally, under the 1974 Act, CON programs will be supported by the necessary planning functions. This could be viewed as an integration of CON requirements with the planning efforts (the Health Systems Plan and the Annual Implementation Plan) of the HSAs. In addition to meeting the CON requirement the facility to be constructed must also be contained in the HSP/AIP and have priority over other programs in the AIP.

Thus we believe, that the concept of CON will be strengthened under the 1974 Act. Not only will the Federal government be involved in the CON programs but the local HSAs will be involved in the implementation of the CON programs.

C. REVIEW AND APPROVAL AUTHORITY

The overall review and approval authority of the Secretary is expected to have at least three practical results. The first is that there will be an increased emphasis on outpatient care. Provisions of the 1974 Act encourage the development and utilization of outpatient facilities, i.e. not less than 25 per cent of a State's allotment is to be used for outpatient facilities. During the proceedings in which the 1974 Act was developed, Congress recommended the use of outpatient facilities whenever feasible and criticized the unnecessary use of the more expensive forms of care. Assuming that HEW agrees with Congress in that outpatient facilities should be utilized and given the requirement in the 1974 Act that construction of outpatient facilities in medically underserved areas receive consideration over construction of inpatient facilities, it may be deduced that the Secretary will critically review any plans to build inpatient facilities.

The Secretary's review function should weaken the influence of provider groups upon the planning efforts of State and local agencies. Under the Comprehensive Health Planning Act provider groups were permitted to make donations to the local planning agencies. This is prohibited under the 1974 Act.

Furthermore, if the Secretary believes that provider groups have adversely influenced the plans of an agency, he may in the review process disapprove the plan.

Operators of health care facilities have been required to make assurances that they will provide a certain amount of free care as a condition of having Federal funds made available for construction purposes. Prior to the enactment of the 1974 Act there was little ability available to ensure that the agreed amount of free care was provided. Under the 1974 Act the Secretary is charged with ensuring that such assurances are fulfilled. Section 1612 of the 1974 Act authorizes the Secretary to withhold future payments to either, all projects within a State or specific projects if he determines that free care is not being provided. Thus pressure can be brought to bear upon either the State or the operator of the facility to ensure the stated amount of free care is provided.

D. REVIEW OF EXISTING FACILITIES

Another major change brought about by the 1974 Act is the periodic review by State and local planning agencies of all existing facilities for the purpose of commenting upon their appropriateness. This is often referred to as the recertification or decertification of need. At the present time there

does not appear to be any reason to believe that "comment upon the appropriateness" implies the ability to decertify a facility. It may be possible that the act of determining that an existing facility is no longer required will in itself result in the disestablishment of that service. We believe that impact of this provision is that it suggests that decertification authority may be coming in the future. If decertification authority becomes a reality it would have a significant impact upon a health care facility's ability to obtain outside financing. Other problems such as determining which one of several similar facilities is the one to be decertified (Do you shut down the proprietary, the not-for-profit or the county-owned hospital?).

It seems that the ability to shut down excess capacity is a requirement if you are trying to control costs, especially considering the impact of the Roemer effect on costs. However, it may have been wise to withhold this authority until the effectiveness of other provisions of the 1974 Act have been demonstrated.

E. UNIFORM COST ACCOUNTING SYSTEMS

The 1974 Act calls for the establishment of a uniform cost accounting system for determining the cost of providing health care and for establishing rates to be charged to the

payors of health care. If such a "uniform" system were ever established it would certainly change planning and development of resources. Planners would be able to more effectively estimate the costs of their plans. Plans could be developed to encourage the utilization of the least cost alternatives. Resource development could be concentrated in the least cost areas. However, we do not believe that such a uniform system is feasible at the present time. A review of the problems experienced with the Cost Accounting Standards used in defense contracting shows that no two organizations interpret costs in the same manner and that the imposition of such standards may drive some organizations "out of the business." If the Federal government operated all health care facilities it would be easier to develop such a uniform system but it still would be a difficult task. There is no mandate that such a system be utilized once it is developed. The concept of a uniform cost accounting system is appealing; however, given the diversity of health care and the various types of organizations involved, we do not believe a "uniform" system is practical. Thus, although this provision appears to be a major change, the change may be a long time in coming.

F. EFFECTS OF CHANGES UPON THE HSA

Some of the major changes brought about by the 1974 Act have been mentioned. Most of these changes have dealt with Federal involvement or System changes such as the Certificate of Need Program. As the impact of these changes flow down through the organizations for planning there will be changes in the planning efforts of local agencies, the Health Systems Agency.

Health Systems Agencies will have significantly larger amounts of funds with which to operate. This should permit the hiring of an adequate number of people in the disciplines required for health planning. Adequate human resources are certainly required when effective planning is required.

The type of data to be utilized by the HSA will be defined. This will require the use of relevant data, relevancy will be determined by the Secretary of HEW. This data will be used when making plans and decisions. Thus decisions will have to be at least partially justified and supported by quantifiable information.

Health Systems Agencies will have specific guidelines to follow in developing plans to attain identified goals. A Health Systems Plan, based in part upon data identifying the status of health resources, will be developed in accordance

with the guidelines provided by HEW. Data identifying health needs will be used to formulate an annual Implementation Plan, which is to be a program for achieving the goals of the Health Systems Plan. Thus, there is a defined method of developing plans - one based on guidelines, existing resources and needs.

Once these two plans, the Health Systems Plan and Annual Implementation Plan, are developed the major change in the function of a local planning agency comes into play. This is the control of development, or a regulatory function. Any organization which wishes to develop a health care facility or modify an existing facility must obtain the approval of the HSA. In order to approve the facility development and thereby request Federal funds be granted to assist development, the HSA must show that the facility development is consistent with its Annual Implementation Plan. Further the facility development proposal must fulfill a health need which has a higher priority than other identified needs.

If the HSA determines the facility is not needed, i.e. it is not consistent with the Annual Implementation Plan, it can recommend that Federal funds not be provided to assist development. Denial of Federal funds for development should prevent the facility from being developed. However, if the

facility is developed, it is possible that the HSA would recommend that the Secretary of HEW terminate other sources of funds available to the facility under the Public Health Service Act.

G. SUMMARY OF CHANGES

In summarizing the changes in health care planning which may result from the 1974 Act we feel the following could be the most significant.

1. The involvement of the Federal government through the issuance of guidelines and regulations which will determine the type of planning and development which will occur.

2. The review and approval or disapproval authority of the Federal government over almost all aspects of planning and development.

3. The consolidation of various funding programs into one planning and development organization.

4. Increased funding for the operation of local planning and development agencies.

5. The ability of local agencies to enact and enforce their plans through a regulatory function.

6. The coordination, even though it may be Federally directed, of national, state and local efforts.

VII. POTENTIAL IMPACT UPON THE MILITARY HEALTH SERVICES SYSTEM (BUMED) AS A RESULT OF THE 1974 ACT

A. PROBABLE IMPACTS

The authors have conducted interviews with the staff of the Mid-Coast Comprehensive Health Planning Association, Salinas, California (the HSA for the counties of Monterey, San Benito, Santa Cruz and San Luis Obispo), the staff of the office of the Regional Program Consultant, Health Planning Branch of the San Francisco Regional Office of the Department of HEW, and the HEW Bureau of Health Resource Planning, Rockville, Maryland. The purpose of these interviews was to attempt to determine if those responsible for implementation of the 1974 Act felt that the Military Health Services Systems (MHSS) should be required to conform to the requirements of that act. Additionally, due to the similarities of the objectives of the provisions of the 1974 Act and the recommendations of the Military Health Care Study (hereafter referred to as the OMB Study)*, interviews were conducted

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*Report of the Military Health Care Study conducted by the Department of Defense, Department of Health, Education and Welfare and the Office of Management and Budget, December 1975, Government Printing Office, Washington, D. C.

with those responsible for planning of the Navy's health care delivery system at the Bureau of Medicine and Surgery, Department of the Navy (BUMED) to determine what, if any, impact might be perceived. It was felt by the authors that the areas of particular concern might be (a) the centralized entity concept to conduct planning, (b) data collection characteristics, and (c) the accounting system proposals.

The authors could not discern any intentions or plans by those responsible for the implementation of the 1974 Act which would impact upon the MHSS. Nor did we perceive those personnel interviewed in BUMED being concerned with the requirements of the 1974 Act being imposed upon the MHSS. The authors could not find any proposed impacts upon the MHSS suggested in the literature which discussed the 1974 Act. However, there are similarities and therefore the possibilities for cooperation and mutual benefit may also be there.

This chapter will attempt to describe some similarities of the 1974 Act and the OMB study using the scenario technique.

B. CENTRALIZED ENTITY CONCEPTS

The centralized entity to conduct health care planning for the 1974 Act is the Secretary of HEW. He is responsible for issuance of national guidelines for health planning policy; the standards respecting the appropriate supply,

distribution and organization of health resources; and for issuing the goals of the 1974 Act. He will monitor and coordinate through his staff organizations (see chapter 4 for the description and responsibilities of these organizations) the State and local HSA planning activities to ensure compliance with the 1974 Act. The "hammer" he has to enforce the act is the ability to withdraw Federal funds to conduct health planning activities from the State and local agencies.

The principle organizational entity he has to assist him is the Bureau of Health Resource Planning. This organization will be responsible to the Secretary to develop the actual guidelines and create the enforcing regulations. Its regional staffs will perform the majority of the Secretary's review and approval functions as well as designate the State and local HSA's.

Recommendation two of the OMB study is that a central entity be established within DOD to serve as a coordinating mechanism for planning and allocation of resources to oversee health care delivery in the continental United States (CONUS). The OMB Study further states that "... the direct care system as currently structured, has demonstrated a high responsiveness to the support of mobilization and contingency forces, however, DOD health care delivery within specific geographic

areas is fragmented."[46] This fragmentation was similar to the findings of the Congress concerning civilian health care delivery. The central entity is to provide the mechanism within DOD for carrying out coordinated planning programming and evaluation of the CONUS MHSS.

The functions of the DOD and HEW central entities are apparent. Even some of the actors are the same. For example, the Assistant Secretary of Defense for Health and Environment is also a member of the National Council of Health Planning and Development required by the 1974 Act. Suppose he was able to convince the Department of Defense that it would be more effective to fall in line with the 1974 Act such that all health care planning, except for mobilization and contingency forces, be carried out as prescribed in the 1974 Act. Health care planning and resource development for all persons within the United States would be carried out under the organizational auspices of HEW. Of course, there might be initial savings by the elimination of similar staffs doing health care planning and there might even be considerable savings generated by more fully utilizing some military or civilian facilities that are not now at capacity.

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[46]P. III-1 of the draft report of the OMB Study.

However, there may not be any real savings realized by integrating these two separate systems of health care delivery. Until the implementing regulations have been written, the HSA's appointed and the Bureau of Health Resources Planning staffed and the 1974 Act fully implemented one can only speculate regarding the potential savings should these actions occur. There are questions that need to be answered however. For example; How would the MHSS integrate with organizations created by the 1974 Act at the local, state and national levels? Would a hospital commander need to get permission from the local HSA to expand his bed capacity or offer a new patient service? What happens when the health resources in an area are underutilized and the military wants to expand its resources in that area? What might occur if either the area HSA or the State do not agree with the MHSS expansion request? Who will determine adequacy - HEW, DOD or some other agency? Will the military have to apply State standards to determine bed capacity and facility size?

Recommendation three of the OMB Study gives the regional authority the ability to control utilization of CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). Given this authority, the regional authority

may arbitrarily decide to "shift" care from the MHSS to the civilian provider if the cost of providing care is less than the cost of the MHSS. Shifting care between the two systems by the military authority will have an impact upon the planning efforts of the HSA.

One of the factors used by the HSA in its planning efforts will be data concerning the population to be served. If the Military will be sending some of its beneficiaries to the civilian sector for care, then the HSA should consider the military beneficiary population in its planning efforts. Additionally, the HSA should have information as to the approximate amount and type of civilian services or resources the military will be using and the anticipated period of time. Problems may occur if significant capital investment is required to meet the military demand. What type of arrangements will have to be made if/when the military decides to no longer utilize the civilian provider. This shifting of demand will require an exchange of information and intentions between the HSA and the regional authority. A coordinated planning effort may avoid overloading the civilian sector or creating excess capacity in the civilian sector.

These are just a few of the many questions that come to mind when two agencies such as DOD and HEW attempt joint planning and resource development efforts in health care delivery.

C. DATA COLLECTION

The 1974 Act requires the HSA's to collect and analyze demographic data to determine the health care needs of that area. The agency is to establish long-range plans to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which will assure continuity of care at reasonable costs for all residents of the area.

Recommendation four of the OMB Study proposes that the MHSS health care delivery planning be based upon the size and demographic characteristics of the population to be served instead of historical workload indicators as is presently done. The CHAMPUS system (provides for medical care in civilian institutions to authorized Armed Services beneficiaries) and the direct care system (medical care provided in military institutions) must be closely integrated in order to develop a set of total requirements, according

to the OMB Study. Therefore, the OMB Study report continues, DOD should adopt a planning process which is based upon the demographics of the population served. This is very similar to the requirement placed upon the HSA in its requirement to develop demographic information. The purpose of this requirement for the 1974 Act and the OMB Study appears to be that once you define the population to be served health care planning can be based upon projected demands for care. Suppose one combined these two systems into a single data collection and reporting activity. It may be relatively easy to program reports to show (1) the total population of an area and/or (2) showing only the MHSS beneficiaries. Again, questions arise in the minds of the authors. For example, how responsive would the system be to the requirements of the DOD? Is it feasible to combine the military and civilian systems? Would the combined systems really benefit either system? Do the two systems need the same information or the same detail of information to effectively manage their resources? We do not believe there are answers to these questions yet.

D. COST ACCOUNTING SYSTEMS

The 1974 Act requires the development of a uniform cost accounting system; for calculating the volume of services; for calculating the rates to be charged to health insurers; for reporting costs, volume of services; and rates charged by health service institutions. Recommendation five of the OMB Study addresses the integration of resource programming between the Direct Care System and CHAMPUS. If a manager is to identify the optimal mix of CHAMPUS and direct care delivery for the DOD as a whole, in each region and in each facility he must have data to compare. Suppose that the military and civilian accounting systems were identical. The manager of the military system could then more easily determine if cost effective activities were being conducted in his region or perhaps introduce cost-tradeoffs between direct care and CHAMPUS. The implementation of such a system might result in the savings of considerable resources for both the military and civilian communities.

The authors repeat that the potential impacts upon the MHSS as a result of the 1974 Act are presently unknown. We will presume that any potential impacts will have to originate from the Office of the President since DOD and HEW are co-equal departments of the government. Should the President

decide to impose certain provisions of the 1974 Act, such as discussed in this chapter, he has the authority to do so. However, we do not believe this is very likely to occur in the near future given the overwhelming task imposed upon HEW to implement the 1974 Act upon the civilian health care delivery system, it seems unlikely that HEW would be willing to take on the additional burden of military health care planning.

In conclusion we do not believe that the 1974 Act will be imposed upon the MHSS in the forseeable future, however, a mutual interchange of ideas should take place between the civilian and military planners. Both communities should derive the benefits of the experiences of the other.

Appendix A

Duties of the Secretary of the Department of Health, Education and Welfare

This listing arranges duties by functional categories such as issuance of regulations, review and approval functions, etc. Categories are subdivided, where appropriate into functions that apply to the national, state and HSA level organizations. References to the applicable section of the 1974 Act are provided following each duty.

I. Issuance of Regulations

A. National

1. Guidelines concerning national health planning policy. Sec 1501 (a).

2. In issuing guidelines concerning national health planning policy, consult with and solicit recommendations from:

(a). Health Systems Agencies

(b). State Health Planning and Development Agencies

(c). Statewide Health Coordinating Councils

(d) National Council on Health Planning and Development

(e). Association and societies representing health care provider. Sec 1501 (c).

B. State

1. Provide procedures for the evaluation of the performance of state health planning and development agencies. Sec 1522 (b) (8).

2. Prescribe the terms and conditions for making grants to state health planning and development agencies. Sec 1525 (b).

3. Prescribe procedures to be followed when a state applies for a grant to assist the development of rate regulation. Sec 1526 (a).

4. Prescribe the requirements a state must fulfill once it has received a grant for rate regulation. Sec 1526 (b) (1) and (2).

5. Prescribe performance standards covering the structure, operation and performance of functions of each State Agency. Sec 1535 (b).

6. Establish a reporting system based on the performance standards that allow for a continuous review of State Agencies. Sec 1535 (b).

7. Prescribe the manner in which each State Agency shall determine for the State Medical facilities plan the

priority among the projects for which assistance is available under the 1974 Act based on the relative need of different areas within the state for such projects. Sec 1602 (1).

8. Require each state medical facilities plan provide for adequate medical facilities for all persons residing in the state and adequate facilities to furnish needed health services for people unable to pay therefore. Sec 1602 (5).

C. HSA

1. Revise boundaries of health service areas if they do not meet the requirements of the law. Sec 1511 (b) (3) (B) (i).

2. Establish health service boundaries for areas not included in the health service area boundaries submitted by state governors. Sec 1511 (b) (3) (B) (ii).

3. Establish standards and criteria for the requirements of the legal structure and functions of a Health Systems Agency. Sec 1512 (a).

4. Issue procedures for terminating agreements designating health systems agencies. Sec 1515 (c) (1) (A).

5. Specify the minimum data needed to determine the health status of the residents of a health service area and the determinants of such status. Sec 1533 (b) (1) (A).

6. Specify the minimum data needed to determine the status of the health resources and services of a health service area. Sec 1533 (b) (1) (B).

7. Specification of the minimum data needed to describe the use of health resources and services within a health services area. Sec 1533 (b) (1) (c).

8. Provide planning approaches, methodologies, policies and standards for appropriate planning and development of health resources. Sec 1533 (b) (2).

9. Provide guidelines for the organization and operation of Health Systems Agencies and State Agencies. The guidelines are to include:

(a). The structure of the agency

(b). The conduct of the planning and development process

(c). The performance of the agency's functions in accordance with Public Law 93-641. Sec 1533 (b) (3).

10. Prescribe performance standards covering structure operation and performance of each HSA. Sec 1535 (b).

11. Establish a reporting system based on the performance standards that allows for a continuous review of HSA's. Sec 1535 (b).

D. General

1. Prescribe, for medical facilities projects assisted by this law, general standards of construction, modernization and equipment for medical facilities of different classes and in different types of location. Sec 1602 (2).

2. Prescribe criteria for determining needs for medical facility beds and needs for medical facilities and for developing plans for the distribution of such beds and facilities. Sec 1602 (3).

3. Prescribe criteria for determining the extent to which existing medical facilities are in need of modernization. Sec 1602 (4).

II. Review and Approval Functions

A. State

1. Determination of an agency's ability to fulfill the requirements of a state health planning and development agency. Sec 1521 (b) (3).

2. Determine the sufficiency of the information contained in the State Administrative Program. Sec 1522 (a) (2).

3. Determine the size and qualifications required of personnel serving on the staff of state health planning and development agencies. Sec 1522 (b) (4) (A).

4. Determine the acceptability of state certificate of need programs. Sec 1523 (a) (4) (B).

5. Review and approve or disapprove the annual budget of each State Agency. Sec 1535 (a).

6. Review in detail at least every three years the structure operation and performance of functions of each State Agency to determine:

(a) the adequacy of the state health plan in meeting the needs of the residents of the state. Sec 1525 (d) (1).

(b) if the structure, operation and performance of functions of the State Agency meet the requirements of Public Law 93-641. Sec 1535 (d) (2).

(c) the extent to which the Statewide Health Coordinating Council has a membership meeting and has performed in a manner consistent with the requirements of Public Law 93-641. Sec 1535 (d) (3).

(d) the professional credentials and competence of the staff of the State Agency. Sec 1535 (d) (4).

(e) the extent to which financial assistance provided under Public Law 93-641 has been used in an effective manner. Sec 1535 (d) (5).

(f) the extent to which it may be demonstrated that:

(1) the health of the residents of the state has been improved.

(2) the accessability, acceptability, continuity and quality of health care in the state has been improved.

(3) increases in the cost of the provision of health care has been restrained. Sec 1535 (d) (6).

B. HSA

1. Review on a continuing basis the appropriateness of the boundaries of health service areas. Sec 1511 (b) (4).

2. Determine an HSAs ability to fulfill the require- of an HSA. Sec 1515 (c) (1).

3. Review and approve or disapprove the annual budget of each HSA. Sec 1535 (a).

4. Review in detail at least once every three years the structure, operation and performance of the functions of each Health Systems Agency to determine:

(a) the adequacy of the Health Systems Plan for meeting the needs of the residents of the area. Sec 1535 (c) (1).

(b) if the structure, operation and performance of functions of the agency meet the requirements of Public Law 93-641. Sec 1535 (c) (2).

(c) the extent to which the agencies governing body represents the residents of the area. Sec 1535 (c) (3).

(d) the professional credentials and competence of the staff of the agency. Sec 1535 (c) (4).

(e) the appropriateness of the data assembled concerning the status of the health of the residents and the quality of the analysis of such data. Sec 1535 (c) (5).

(f) the extent to which technical and financial assistance from the agency have been utilized in an effective manner to achieve goals and objectives of the HSP and AIP. Sec 1535 (c) (6).

(g) the extent to which it may be demonstrated that:

(1) the health of the residents has been improved

(2) the accessibility, acceptability, continuity and quality of health care has been improved.

(3) increases in costs in the provision of health care have been restrained. Sec 1535 (c) (7).

C. General

1. Approve/disapprove applications for grants to assist the construction or modernization of medical facilities. Sec 1604 (b) and Sec 1604 (c).

III. Designation Functions

A. State

1. Enter into and revew agreements designating state health planning and development agencies. Sec 1521 (a).

B. HSA

1. Enter into agreements for the designation of health systems agencies. Sec 1515 (a).

2. Renew agreements designating health systems agencies. Sec 1515 (c) (3).

IV. Granting of Funds

A. National

1. Provide by grants, contracts or both, assistance to establish at least five centers for health planning. Sec 1534.

2. May make loans to pay the federal share of approved projects for construction or modernization of medical facilities. Sec 1620 (a).

3. May make grants for construction or modernization projects to:

(1) eliminate or prevent imminent safety hazards or (2) to avoid non-compliance with State or voluntary licensure or accreditation standards. Sec 1625.

B. State

1. Make grants to state health planning and development agencies to assist them in meeting their costs. Sec 1525 (a).

2. Determine the amount of a grant to be given to a state health planning and development agency. Sec 1525 (a).

3. Make grants to state agencies to be used for the purpose of demonstrating the effectiveness of rate regulation programs. Sec 1526 (a).

4. Provide either through grants, contracts or both, to designated State Agencies:

(a) Assistance in developing their plans and approaches to planning various types of health services.

(b) Technical materials for use in health planning.

(c) Other technical assistance as may be necessary in order that the agencies may properly perform their functions. Sec 1533 (a).

5. Each fiscal year make allotments among the States based upon population, financial need and the need for medical facilities of the respective states. Sec 1610 (a).

6. Withhold payments from allotments to states under certain conditions. Sec 1611 (b) and Sec 1612 (a).

C. HSA

1. Make grants to health systems agencies to be used for the operations of the agency. Sec 1516 (a).

2. Determine the amount of any grant to a conditionally designated health systems agency. Sec 1516 (b) (1).

3. Provide either through grants contracts or both to designated HSAs:

(a) assistance in developing their plans

(b) technical materials for use in health planning

(c) other technical assistance as may be necessary in order that an HSA may properly perform their functions. Sec 1533 (c).

V. Miscellaneous Functions

1. Report annually to Congress on the effectiveness of rate regulation programs. Sec 1526 (d).

2. Establish a national health planning information center to support the health planning and resource development

programs of Health Systems Agencies and State Agencies. Sec 1533 (c).

3. Establish a uniform system for calculating the aggregate cost of operation and the aggregate volume of services provided by health services institutions. Sec 1533 (d) (1).

4. Establish a uniform system of cost accounting and calculating the volume of services provided by health services institution. Such systems shall include:

(a) establishment of specific cost centers

(b) designation of the appropriate volume factor for each cost center.

(c) provide for the appropriate application for such systems in different types and sizes of health care institutions. Sec 1533 (d) (2).

5. Establish a uniform system for calculating the rates to be charged to health insurers and other health institution payors by health services institutions. Such systems shall:

(a) be based on an all-inclusive rate for various categories of patients.

(b) provide such rates reflect the true cost of providing services to each category of patients.

(c) provide that revenues derived from patients in one category shall not be used to support the provision of services to patients in any other category.

(d) provide for the appropriate application of the system to different types and sizes of institutions.

(e) provide that differences in rates to various classes of purchasers be based on justified and documented differences in the costs of operation of health service institutions made possible by the actions of such purchasers. Sec 1533 (d) (3).

6. Establish a classification system for health services institutions. Sec 1533 (d) (4).

7. Establish a uniform system for the reporting of health services institutions of:

(a) the aggregate cost of operation and volume of services

(b) the cost and volume of services at various cost centers

(c) rates by category of patient and class of purchaser. Sec 1533 (d) (5).

Appendix B

Requirements of a State Administration Program

The Secretary of DHEW may not approve a State Administrative Program unless it

A. has been submitted to the Secretary by the state governor at such time and in such detail, and contains or is accompanied by such information, as the Secretary deems necessary and

B. has been submitted to the Secretary only after the state governor has afforded the general public of the state a reasonable opportunity for a presentation of views on the State Administrative Program. Sec 1522 (a).

Additionally a State Administrative Program must:

1. Provide for the performance within the state of the functions of a State Agency. Sec 1522 (b) (1).

2. Specify the State Agency as the sole agency for the performance of the functions of a State Agency. Sec 1522 (b) (1).

3. Contain or be supported by satisfactory evidence that the State Agency has under state law the authority to carry out the functions of a State Agency. Sec 1522 (b) (2).

4. Contain the current budget for the operation of the State Agency. Sec 1522 (b) (2).

5. Provide for the adequate consultation with, and authority for, the Statewide Health Coordinating Council. Sec 1522 (b) (3).

6. Set forth in such detail as the Secretary may prescribe, the qualification for personnel having responsibilities in the performance of a State Agencies functions. Sec 1522 (b) (4) (A).

7. Require the State Agency to have a professional staff for planning and a professional staff for development. Sec 1522 (b) (4) (A).

8. Provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the functions of a State Agency. Sec 1522 (b) (4) (B).

9. Require the State Agency to perform its functions in accordance with procedures and criteria established and published by it; which shall conform to the requirements of Public Law 93-641. Sec 1522 (b) (5).

10. Require the State Agency to conduct its business meetings in public, give adequate notice to the public of such meetings and made its records and data available, upon request, to the public. Sec 1522 (b) (6).

11. Provide, in accordance with methods and procedures prescribed or approved by the Secretary, for the evaluation, at least annually, of the performance by the State Agency of its functions and their economic effectiveness. Sec 1522 (b) (8).

12. Provide that the State Agency will at least annually review the State Program and submit to the Secretary required modifications. Sec 1522 (b) (9).

13. Require that the State Agency make reports such as the Secretary may require, and to keep such records and afford such access thereto as the Secretary may find necessary to verify such reports. Sec 1522 (b) (10).

14. Require the State Agency to provide for such fiscal control and fund accounting procedures as the Secretary may require to assure proper disbursement and accounting for amounts received from the Secretary. Sec 1522 (b) (11).

15. Permit the Secretary and the Comptroller General to have access for the purpose of audit and examination to any books of the State Agency pertinent to the disposition of amounts received from the Secretary. Sec 1522 (b) (12).

16 Provide that if the State Agency makes a decision pertaining to the CON program, new institutional health

services, the state medical facilities plan, or the review of existing institutional health facilities, which is inconsistent with a recommendation made by a Health Systems Agency, such a decision shall, upon request of the Health Systems Agency be reviewed under an appeals mechanism consistent with state law. Sec. 1522 (b) (13).

Appendix C

Functions of A
State Health Planning and Development Agency

1. Conduct the health planning activities of the State. Sec 1523 (a) (1).
2. Implement those parts of the State Plan and the plans of the Health Systems Agencies which relate to the government of the state. Sec 1523 (a) (1).
3. Prepare and review and revise at least annually a preliminary state health plan which shall be made up of the health systems plans of the Health System Agencies of the state. Sec 1523 (a) (2).
4. Submit the preliminary state health plan to the Statewide Health Coordinating Council for approval. Sec 1523 (a) (2).
5. Assist the Statewide Health Coordinating Council in the review of the state medical facilities plan. Sec 1523 (a) (3).
6. Serve as the designated planning agency of the state for the purposes of section 1122 of the Social Security Act. Sec 1523 (a) (4).
7. Administer a state certificate of need program which applies to new institutional health services proposed

to be offered or developed within the State and which is satisfactory to the Secretary. Sec 1523 (a) (4).

8. After consideration of recommendations submitted by a Health Systems Agency concerning the need for new institutional health services, make findings as to the need for such services. Sec 1523 (a) (5).

9. Review at least once every five years all institutional health services being offered in the state and after consideration of recommendations of Health Systems Agencies respecting the appropriateness of such services, make public its findings. Sec 1523 (a) (6).

10. Complete its findings with respect to the appropriateness of any existing institutional health services within one year after the date a Health Systems Agency has made its recommendation with respect to the appropriateness of the service. Sec 1523 (b) (3).

11. If a State Agency makes a decision relating to certificate of need, new institutional health services or review of existing institutional health services, which is not consistent with the goals of the applicable Health Systems Plan or the priorities of the applicable Annual Implementation Plan, the State Agency shall submit to the appropriate Health Systems Agency a detailed statement of the reasons for the inconsistency. Sec 1523 (c).

Appendix D

Functions of a
Statewide Health Coordinating Council (SHCC)

1. Review annually and coordinate the Health Systems Plan (HSP) and Annual Implementation Plan (AIP) of each Health Systems Agency within the state. Sec 1524 (c) (1).
2. Report to the Secretary, for the purposes of his review, its comments on such HSP and AIP. Sec 1524 (c) (1).
3. Prepare and review and revise at least annually a state health plan which shall be made up of the HSP's of the Health Systems Agencies. Such plan may, as found necessary by the SHCC, contain revisions of HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs. Sec 1524 (c) (2) (A).
4. Review and consider the preliminary state health plan prepared by the State Agency when preparing and revising the state health plan. Sec 1524 (c) (2) (B).
5. Conduct public hearings on the state health plan as proposed and give interested persons an opportunity to submit their views orally and in writing. Sec 1524 (c) (2) (B).

6. Review annually the budget of each Health Systems Agency and report to the Secretary for the purpose of his review, its comments on such budget. Sec 1524 (c) (3).
7. Review applications submitted by Health Systems Agencies for grants to be used for personnel compensation, collection of data, planning and the performance of functions, or for grants to establish an Area Health Services Development Fund. Report to the Secretary its comments on such applications. Sec 1524 (c) (4).
8. Advise the State Agency generally on the performance of its functions. Sec 1524 (c) (5).
9. Review annually and approve or disapprove any State Plan and any application submitted to the Secretary as a condition to the receipt of any funds under allotments made to States by this act and several other acts. Sec 1524 (c) (6).

Appendix E

Responsibilities of an HSA Governing Body

The governing body of an HSA shall have the following responsibilities under section 1512 (3) (B) of the Act.

1. Responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria applicable to its functions under subsections (e), (f), and (g) of section 1513*. Sec 1512 (B) (i).

2. Responsible for establishment of the health systems plan and annual implementation plan required under section 1513 (b). Sec 1512 (B) (ii).

3. Responsible for the approval of grants and contracts entered into under section 1513 (c) (3). Sec 1512 (B) (iii).

4. Responsible for the approval of all actions taken pursuant to subsection (e), (f), (g), and (h) under section 1513. Sec 1512 (B) (iv).

5. Shall (1) issue an annual report concerning the activities of the agency, (2) include in that report the

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*Section 1513, functions of health services agencies, is the subject of Appendix F.

health systems plan, and annual implementation plan developed by the agency, and a listing of the agency's income, expenditures, assets, and liabilities and (3) make the report readily available to the residents of the health services area and the various communication media serving such an area. Sec 1512 (B) (V).

6. Reimburse its members for their reasonable costs incurred for attending meetings of the governing body. Sec 1512 (B) (VI).

7. Meet at least once in each calendar quarter and shall meet at least two additional times (totals six meetings per year) unless its executive committee meets at least twice in a year. Sec 1512 (B) (vii).

8. Conduct its meetings in public, giving adequate public notice, making its records and data available, upon request, to the public. Sec 1512 (B) (viii). The governing body (and executive committee if any) of an HSA shall act only by vote of a majority of its members at which a quorum is present of not less than one half of its members.

Appendix F

Functions of Health Systems Agencies

In providing health planning and resource development for its health service area, a health systems agency (HSA) shall perform the following functions in accordance with section 1503 of the 1974 Act.

1. Assemble and analyze data concerning ---
   - (A) the status (and its determinants) of the health of the residents of its health service area,
   - (B) the status of the health care delivery system in the area and the use of that system by the residents of the area,
   - (C) the effect of the area's health care delivery system has on the health of the residents of the area,
   - (D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,
   - (E) the patterns of utilization of the area's health resources and
   - (F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

In carrying out this subsection, the agency shall to the maximum extent possible use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for. Sec 1513 (b) (1) (A) thru (F).

2. The agency shall, after appropriate consideration of the recommended guidelines for health planning policy (not yet issued) and in accordance with the priorities set forth in section 1502 along with the data developed - establish, annually review, and amend as necessary a health systems plan (HSP) which shall be a detailed statement of goals

(A) describing a healthful environment and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at a reasonable cost, for all residents of the area;

(B) which are responsive to the unique needs and resources of the area; and

(C) which will take into account and is consistent with the national guidelines for health planning policy issued by the Secretary under section 1501 respecting supply distribution, and organization of health resources and services. Sec 1513 (2).

3. Annually review and amend as necessary an annual implementation plan (AIP) which describes objectives which will achieve the goals of the HSP and priorities among the objectives. Sec 1513 (3).

4. Develop and publish specific plans and projects for achieving the objectives established in the AIP. Sec 1513 (4).

5. Implement the HSP and AIP and in implementing the plans shall perform the following functions:

(A) Seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals, public and private entities in its health service area. Sec 1513 (c) (1).

(B) The agency may provide, in accordance with the priorities established in the AIP, technical assistance to individuals, public and private entities for the development of projects and programs which the agency determines are necessary to achieve the health systems described in the HSP, including assistance in meeting the requirements of the agency prescribed under section 1532 (b).* Sec 1513 (c) (2).

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*Section 1532, Procedures and criteria for review of proposed health system changes, is the subject of Appendix G.

(C) The Agency shall make grants to public and non-profit private entities and enter into contracts with individuals, public and nonprofit private entities to assist them in planning and developing projects and programs which the agency determines are necessary for the achievement of the health systems described in the HSP. Sec 1513 (c) (3).

6. Each HSA shall review and approve or disapprove each proposed use within its service area of Federal funds (a) appropriated under this act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 for grants, contracts, loans or loan guarantees for the development, expansion, or support of health resources; or (b) made available by the state in which the HSA is located. Sec 1513 (e) (1) (A).

There are several prohibitions against this review and approval authority pertaining to (1) Indian reservations, (2) Indian trust lands, (3) native Alaskan Village and (grants and contracts under Titles IV, VII, or VIII, of this act. Sec 1513 (E) (1) (B).

7. Each HSA shall review on a periodic basis (but at least every 5 years) all institutional health services offered

in a health service area and shall make recommendations to the State Health Planning and Development Agency respecting the appropriateness of such services. Sec 1513 (2) (g) (1).

8. Each HSA shall annually recommend to the State Health Planning and Development Agency

(A) projects for modernization, construction, and conversion of medical facilities which will achieve the HSP and AIP of the HSA. Sec 1513 (2) (g) (2) and (h) (1) (2).

Appendix G

Procedures and Criteria for Reviews of Proposed Health Systems Changes

In conducting reviews pursuant to subsection (e), (f), and (g) of section 1513 or in conducting any other reviews of proposals or existing health services, each health systems agency shall (except to the extent approved by the Secretary) follow procedures and apply criteria, developed and published by the agency. Sec 1532 (a). These procedures must include at least the following:

(1) Written notification to affected persons of the beginning of the review.

(2) Schedules for reviews which provide that no review shall, to the extent practicable, take no longer than ninety days from the date the notification is made. Sec 1532 (b) (2).

(3) Provision for persons subject to review to submit to the agency (in such form and manner as the agency shall prescribe and publish) such information as the agency may require concerning the subject of such review.

(4) Submission of applications (subject to review by a health systems agency) made under this Act or other provisions of law for Federal financial assistance for health services

to the HSA at such time and in such a manner as they may require.

(5) Submission of periodic reports by providers of health services and other persons subject to agency review.

(6) Provision for written findings which state the basis for any final decision or recommendation made by the Agency.

(7) Notification of providers of health services and other persons subject to Agency review of the status of that review, findings made in the course of that review and other appropriate information respecting such review.

(8) Provide for public hearings in the course of the review if requested by persons directly affected by the review. Public hearings shall also be provided if good cause is shown respecting agency decisions.

(9) Prepare and publish regular reports of the reviews being conducted (including a statement of the status of each review) by the agency.

(10) Provide access to the general public to all applications reviewed or being reviewed as well as all other pertinent written materials.

(11) In the case of construction projects, submission to the agency by the entities proposing the projects of letters of intent in sufficient detail to inform the agency of the

scope and nature of the projects at the earliest possible opportunity in the course of planning for such a construction project. See 1532 (b) (1) thru (11).

The criteria for review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable HSP and AIP.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need of the population served or to be served by such services.

(4) the availability of less costly alternatives and/or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or are proposed to be provided.

(6) Where health services are proposed to be provided, the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services and the availability of alternative uses of such resources for the provision of other health services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services and/or resources to individuals not residing in the health service area in which the entities are located. These entities may include medical and other health professions, school, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may prescribe.

(8) The special needs and circumstances of Health Maintenance Organizations for which assistance may be provided.

(9) In the case of a construction project --

(A) The cost and methods of the proposed construction, and

(B) The probable impact of the construction project reviewed on the costs of providing health services by the persons proposing such construction projects. Sec 1532 (c) (1) thru (9).

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