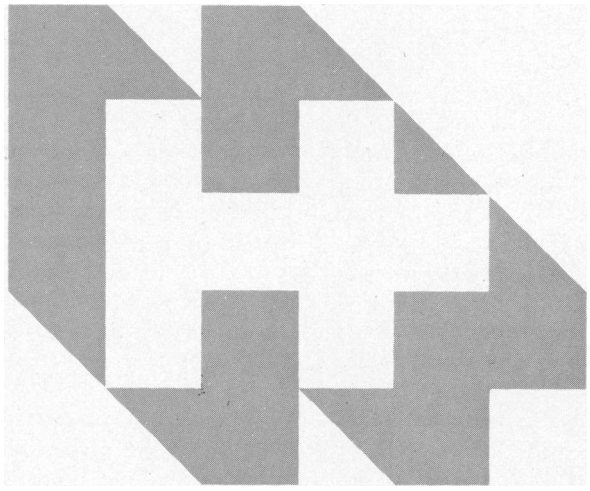
Implementing the National Health Planning and Resources Development Act of 1974



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THE NATIONAL HEALTH PLANNING and Resources Development Act of 1974 (Public Law 93–641), signed by President Ford on January 4, 1975, provides a new, unified approach to resolving the problems of access, cost, and quality of care that have been plaguing our health care system for the past 10 years.

The law builds upon the experience of the Hill-Burton, regional medical, and comprehensive health planning programs, combining the best features of each into a single new program of State and local planning and development. It also provides for a new special projects grant program to meet our nation's urgent need for health facilities and for new regulatory programs to control costs.

The law's purpose, as stated in its preamble, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower and facilities, and to authorize financial assistance for the development of resources to further that policy."

The major features of the new law and the steps that are being taken to implement it are presented in this report.

Summary of Law

Public Law 93–641 adds the following two new titles to the Public Health Service Act:

- The first, a new title XV, creates a national network of local health systems agencies (HSAs), State health planning and development agencies (SHPDAs), and statewide health coordinating councils (SHCCs) re-

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sponsible for health planning and resources development throughout the country. It also establishes a new National Council for Health Policy, within the Department of Health, Education, and Welfare, which is charged with assisting the Department in developing guidelines for national health planning policy based upon national health priorities specified in the law.

- A new title XVI provides for Federal financial assistance for construction of health care facilities, particularly for modernization of existing facilities and for the development of new outpatient facilities.

The law strongly emphasizes local health planning, and unprecedented control over health service development is vested in the local and State health planning agencies. For example, the local health systems agencies are required to review and approve or disapprove applications for Federal health program funds and to conduct periodic reviews of the "appropriateness" of all existing institutional health services in their health service areas. The local HSAs are also authorized funds for development of health resources to implement their plans. This is the first time that a planning agency has been given authority for implementation in addition to planning.

An important adjunct to the emphasis on local health planning is the requirement in the law that the Federal Government provide the HSAs and State agencies with substantial technical assistance. This requirement recognizes that the state of the art of health planning must be advanced if the local health planning approach is to be effective.

Another major emphasis of the law is on participation in health planning by all segments of the health care system—direct providers, third-party payers, health education institutions, government, and consumers. Significant consumer and provider representation on local and State planning agency boards is mandated under the law.

Affirmation of strong and effective certificate of need programs is another key feature of the law. For the first time, every State will have to establish and administer a certificate of need program with sanctions to prohibit the development of unneeded services.

The law also focuses on rate regulation as a possible method for holding down health care costs. Federal grants are to be made available under the law for up to six States that want to develop projects to demonstrate the effectiveness of State regulation of provider rates.

Finally, the law authorizes transitional funding through fiscal year 1976 for areawide and State comprehensive health planning agencies (CHPs), regional medical programs (RMPs), and experimental health service delivery systems (EHSDS).

Implementation of Public Law 93-641

The major responsibility for implementing Public Law 93–641 resides in the Bureau of Health Planning and Resources Development (BHPRD), which was established in March 1975 as a component of the Public Health Service's Health Resources Administration. The Bureau is organized along program lines, with four staff offices and four program divisions reporting to the Director (see chart).

Because of the decentralized nature of health planning and resources development under the law, the major responsibility for the day-to-day operation of the program rests within the 10 Public Health Service Regional Offices. In addition, a number of provisions in the law go beyond the basic health planning and resources development functions housed in the Bureau of Health Planning and Resources Development. For example, there is a requirement for the development of national guidelines for health planning policy by a new National Council on Health Planning and Development, as well as provisions for grants for State-administered rate-regulation experiments and for uniform systems for cost analysis, rate setting, institutional classification, and reporting. Other issues central to the planning program will impact heavily on the Medicare and Medicaid programs. In response to these issues, a HEW departmental committee has been established to oversee the implementation of the preceding objectives and to resolve important Department-wide issues stemming from Public Law 93–641.

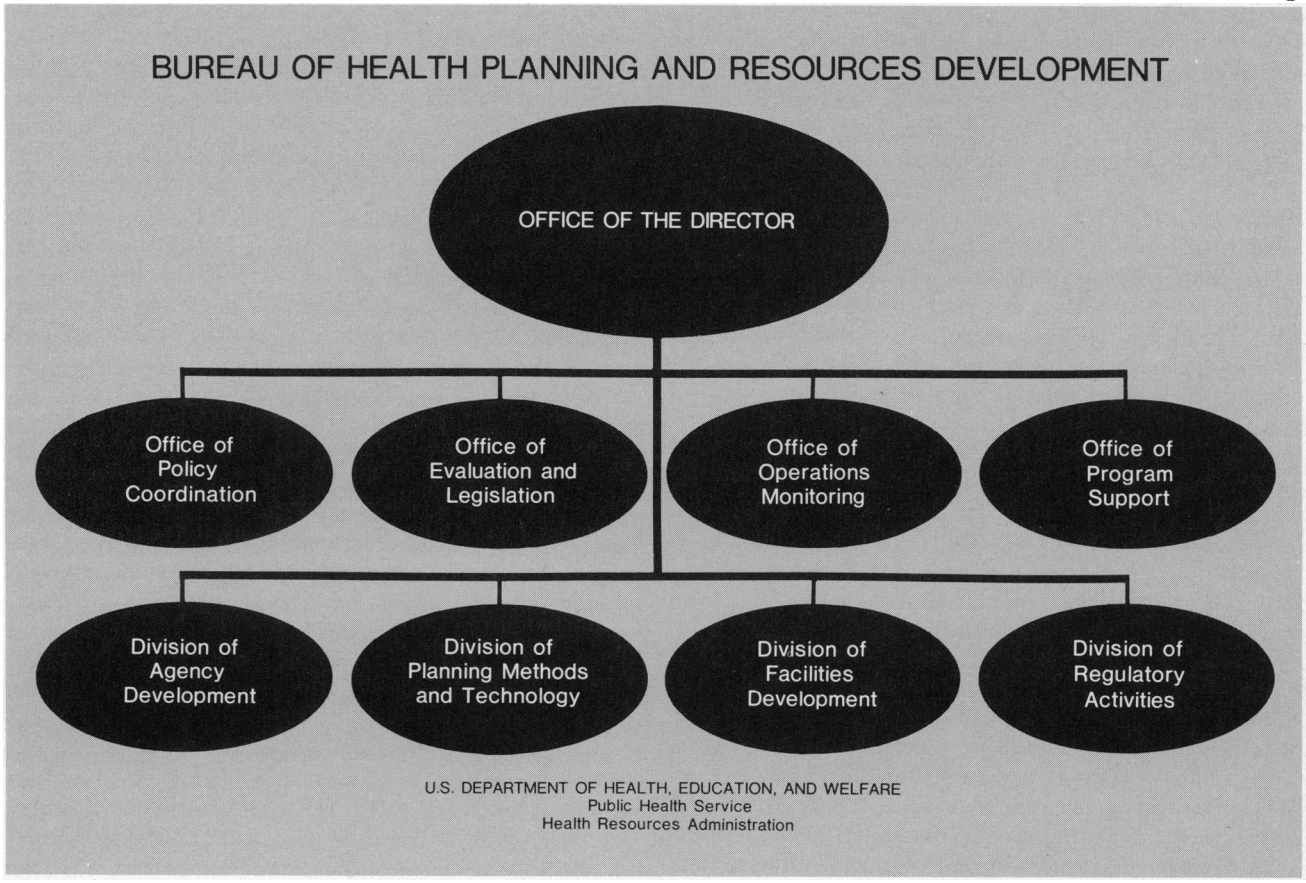
The committee is charged with the responsibility for coordinating the development within DHEW of the national guidelines for health planning policy, including (*a*) developing appropriate national standards and goals required by the legislation, (*b*) considering issues of goal quantification, and (*c*) resolving conflicts therein.

A second major responsibility for the committee is overseeing and coordinating the conduct of the rate review and uniform systems provisions that are being administered by the Social Security Administration. The committee will also facilitate review and clearance of policies and regulations relating to other provisions.

The committee is co-chaired by the Assistant Secretary for Health of HEW and the Deputy Assistant Secretary for Health Planning and Evaluation and includes representatives from the Office of the Secretary, the Health Resources Administration, the Health Services Administration, the Alcohol, Drug Abuse, and Mental Health Administration, the Social and Rehabilitation Service, and the Social Security Administration. Most of the staff support will come from the Health Resources Administration.

Transition Activities

Devising a transition strategy for comprehensive health planning agencies, regional medical programs, and experimental health service delivery systems has been given high priority by the Department. The uncertainty regarding the future of these programs during the time that Public Law 93–641 was being debated in the



Congress resulted in a loss of morale and, consequently, of staff in many agencies.

Since the law allows for transitional funding for these agencies, funds made available by the second supplemental appropriation for fiscal year 1975 were used to support them. When necessary, additional funds from fiscal year 1976 appropriations will be used to insure that the existing agencies will have full opportunities to participate in the designation of the new agencies. To deal with the problems facing the existing programs and to coordinate transition activities generally, a special Office for Transition Management has been established in the Office of the Director of the Bureau of Health Planning and Resources Development.

Health Service Areas

As an initial step in establishing the local-State health planning network called for in Public Law 93–641, the law requires the Secretary, in cooperation with State Governors, to designate health planning districts within all States and Territories. These health service areas must meet certain demographic, economic, and geographic criteria prescribed in the law, unless waived by the Secretary. Therefore, shortly after the law was enacted, on January 21, 1975, the Secretary wrote to all the State Governors asking them to designate health service areas within their respective States. During the next few months, Department staff, working closely with the regional offices, reviewed the Governors' recommendations.

The area designation process is now complete, with the exception of Hawaii, Vermont, and Delaware—202 health service areas have been designated in 47 States (published in the Federal Register, September 2, 1975). Rquests for waivers submitted by Vermont and Delaware have been denied, and both States have been asked to submit area designation plans. Rhode Island and the District of Columbia have been exempted from the designation process, and Hawaii's waiver request is still under study in the Department. (A more detailed discussion of the area designation process is presented by Peterson, beginning on page 9 in this issue.)

Regulations

Drafting of implementing regulations has been a major focus of the Department since Public Law 93–641 was enacted. As an initial step in this process, the Department produced a list of the major policy issues involved in the law. It then adopted a three-stage procedure for drawing up specifications for draft regulations. This procedure was designed to insure maximum participation of all concerned parties in each stage of the specification development process. The guidelines for

this procedure emphasized that all persons who could be instrumental in specifications development—DHEW staff members, regional office staff, and representatives of national organizations—were to be consulted at all stages of specifications development.

The three stages of specifications development are:

Identification of issues. Every issue identified is analyzed to determine whether it should be addressed in regulations. Issues proposed for inclusion in regulations are circulated to all parties in the form of clear, concise statements (or questions) that indicate which section of the act is concerned and what problems or conflicts exist in respect to that section.

Option analyses. In preparing option analyses, Department staff are required to describe the major alternatives to each controversial issue and invite comments on those alternatives. Once all parties have had an opportunity to comment on the options presented, summaries of their comments are incorporated into an options paper, which is submitted for approval before detailed specifications are drafted.

Final specifications. When decisions have been made as to which options should be taken in regard to each set of related issues, Department staff begin to prepare final specifications for that area. Final specifications are in the form of a draft policy document accompanied by a summary memorandum addressing the major policies proposed.

The Department's tentative schedule for publication of proposed regulations is as follows:

Regulations governing—	*Notice of proposed rulemaking published*
Health systems agencies	October 17, 1975
State agencies, statewide health coordinating councils, certificate of need	January 1975
Section 1122	January 1975
Assurances	January 1976
Facility construction, formula grants, loans and loan guarantees, project grants	January 1976
Specifications for health systems plan, annual implementation plan, State plan	January 1976
Review and approval	March 1976
Area health services development fund	June 1976
Performance standards	June 1976

Agency designation. The major components of the program that require implementation before other components can succeed are the health systems agencies and State agencies. Thus, top priority has been given to the promulgation of regulations establishing requirements and procedures for designation and funding of HSAs and to producing applications and preliminary requirements to be followed in securing designation as an HSA.

Under the law, the Secretary, in cooperation with each Governor, is to designate and fund in each health service area a health systems agency which will be responsible for the provision of effective health planning for its area and the promotion of improved health services, manpower, and facilities that will meet identified needs in the most efficient and effective manner. The major functions of an HSA include (*a*) collecting and analyzing data related to health planning, (*b*) establishing a health systems plan, (*c*) developing an annual implementation plan, (*d*) making grants and contracts from the area resources development fund, (*e*) making recommendations to the State agency on the need for new institutional health services proposed to be offered in the area and on the "appropriateness" of all existing health services in the area, and (*f*) recommending to the Secretary approval or disapproval of proposed uses of certain Public Health Service funds.

A health systems agency can be either a nonprofit private corporation or a public agency operating under the auspices of a unit of general-purpose local government or a public regional planning body. Every HSA must have a governing body for health planning composed of consumers, providers, and local government representatives. The law also specifies minimum criteria for an HSA's legal structure, staffing, governing body, and functions.

Because the provisions of the statute governing the HSAs are relatively specific, the HSA Notice of Proposed Rulemaking (NPRM), published in the October 17, 1975, Federal Register, proposed additional requirements only where necessary for clarification or where mandated by the statute itself.

The single, most controversial issue covered in the NPRM concerns the relationship between the governing body of a public HSA and the sponsoring agency's governing board—for example, a county board of supervisors and the governing body of a council of governments. The law states that the governing body of a public HSA has "exclusive authority to perform the functions of the agency." After considerable discussion of this issue, the Secretary concluded that the relationship between the regular public governing board of a public HSA and its separate governing body for health planning is governed by the language of the statute. This conclusion permits—but does not mandate—the regular public governing board to exercise considerable authority. Included is the authority to (*a*) select and remove members of the separate governing body for health planning, (*b*) establish personnel policies and review the appointment of the executive director and staff, (*c*) establish, execute, and revise the agency's budget, (*d*) set rules and regulations for the functioning of the agency, and (*e*) review and comment on any proposed action of the separate governing body. However, the governing body for health planning must have the sole authority to act for the agency in performing its function.

Several other major provisions in the HSA Notice of Proposed Rulemaking follow:

Governors' roles in designation of HSAs. According to the NPRM, the Secretary intends to consult actively with Governors and to give considerable weight to their recommendations. Eligible applicants are encouraged to contact Governors for a description of any issues or procedures which the Governors consider necessary for applicants to address. The Governors must be given 30 days to review applications. Should the Secretary not accept a Governor's recommendation, he must provide the Governor with a detailed statement of the reasons for the decision.

Governing body composition. No more than one-third of the total membership of the governing body of a private HSA (or the separate governing body for health planning of a public HSA) may be public officials. This requirement has been added to insure that a private agency is not so dominated by public members that it becomes, in effect, a public agency. Furthermore, even public agencies are required by the law to have a separate governing body for health planning, and the limitation in this case insures that the private sector will be adequately represented in public agencies.

Conditional designation. All HSAs must operate under a conditional designation agreement for at least 1 year before they may be fully designated. During the period of conditional designation, an HSA must perform a minimum set of functions concerning data analysis, planning, coordination, and the review of new institutional health services proposed for its area, and it must maintain a governing body which meets all legal requirements. During the first year of conditional designation, an HSA may not perform the review and approval function or the review of existing institutional health services as described in sections 1513(e) and (g), respectively, of the act. An HSA must have developed its health systems plan and annual implementation plan before it may perform these review functions.

Designation criteria. The Secretary, after consultation with the appropriate Governor and other appropriate State and local officials and consideration of their recommendations, may enter into a conditional designation agreement with an entity whose designation will best promote the purposes of the act. Selection criteria include consideration of the applicant's:

1. Proposed work program,
2. Financial resources,
3. Governing body selection procedures,
4. Inclusion of area residents in preparation of the application,
5. Knowledge of area needs and resources,
6. Plans for developing necessary relationships with other appropriate agencies, and
7. Response to unique circumstances within a State.

Applicants are required to describe the manner in which area residents and local officials have been engaged in development of the application. Furthermore, the applicant must have sponsored a public meeting to obtain views on the applicant's qualifications.

Coordination with other HSAs. HSAs designated within areas that include parts of the same standard metropolitan statistical area must enter into agreements which promote coordinated planning and resource development.

Public access and involvement. An HSA must adopt bylaws that describe the manner in which the public will be given adequate notice of its business meetings, which must be conducted in public. An HSA must make its data and records available to the public, and it must provide for widespread dissemination of its plans and its annual report.

Contracting for services. An HSA may contract with other entities for assistance in the performance of its functions; but it may not contract for the performance of an entire function specified in its designation agreement, and it may not contract for the performance of routine planning functions.

Data systems. When an HSA wishes to undertake the design, development, and operation of a new data system, it must obtain prior approval from the Secretary.

Because of the urgency of expediting the HSA designation process, the Department has limited the period for public comment on the NPRM to 30 days. In addition, it has agreed to accept applications based on the NPRM, with the proviso that appropriate amendment of applications will be allowed if the final regulation differs from the NPRM. By taking this approach, the Department expects to designate the great bulk of HSAs by late March 1976.

The following schedule has been developed for designation of HSAs:

Letters of intent from potential applicants to A–95 agencies, Governors, and regional offices	December 1, 1975
Development and review of applications within health service areas (public comments sought by applicants)	November–December 1975
Application deadline	January 19, 1976
Start of Federal review; Governors' formal review; A–95 reviews	January 19, 1976
Governors' recommendations	February 18, 1976
Negotiations and decisions	February–March 1976
Designation and funding	Before March 31, 1976

To the extent that an agency is not designated in this cycle, additional cycles will be available, including one which requires applications to be submitted by

March 1, 1976, with designation and funding by July 1, 1976.

Although the HSAs perform health planning and resources development functions on the local level, the State health planning and development agencies and the statewide health coordinating councils have an extremely important role in conducting statewide health planning and resources development and in performing certain regulatory functions under the law. Therefore, another Department priority has been the development of draft regulations governing the designation of these agencies and guidelines covering their operations, as well as applications and preliminary requirements to be followed in securing designation as a State agency. The Department's goal was to publish its NPRM on the State agencies by January 1976 and to be able to designate most of the agencies by June 1976.

To be designated, each State agency must prepare and submit to the Secretary for approval an administrative program for carrying out its functions. The development of guidelines for the State administrative program is being facilitated by a contract with the National Governors Conference, which has organized a consortium of States to advise on this issue. The consortium held its first meeting in early October 1975 and is expected to produce a model State administrative program by February 1976.

Technical Assistance

Public Law 93–641 contains a variety of provisions designed to improve the health planning and resources development process throughout the country and to provide assistance and support to the planning agencies developed under the law in their performance of their activities. Of these measures, the most important is a requirement that the Secretary establish at least five regional health planning centers to provide technical and consulting assistance to HSAs and State agencies, to conduct research, to undertake studies and analyses of health planning and resources development, and to develop health planning approaches, methodologies, policies, and standards. These centers, which are to be operational within the next 2 years, will be staffed with a multidisciplinary staff of experts in health issues, planning processes, and such related matters as data gathering and analysis, economics, and organization and operation of planning agencies.

The Department expected to select up to 10 centers, 1 for each DHEW Region, by December 31, 1975. Proposals from organizations seeking to become a center for health planning were invited in early October 1975.

Another important aspect of the law's technical assistance provisions is the requirement that the Secretary develop the minimum data sets needed to determine the health status of the residents of a health service area and the status of its health resources and services and to describe the use of health resources and services within that area. To implement this section of the law, the Bureau has an agreement with the National Center for Health Statistics (NCHS) which should assure that the HSAs and State agencies have the benefit of NCHS's experience and expertise—both in-house and through their contractual arrangements, as in the Cooperative Health Statistics System (CHSS). This agreement provides that NCHS will assist the Bureau by performing the substantive work and research in developing health data systems, identifying useful health indicators, and providing training for planning agency staff.

To help maintain the closest possible cooperation and coordination in implementing this joint health data activity, an Inter-Bureau Committee on Health Statistics-Health Planning and Resources Development has been established with representatives from the National Center for Health Statistics, the Bureau of Health Planning and Resources Development, and the Health Resources Administration.

Budget

As of this writing, the fiscal year 1976 appropriations bill for the Department has not yet come before a House-Senate Conference Committee. It is expected that the health planning and resources development program will be funded somewhere between the $186 million provided in the House bill and the $180 million allowed in the Senate bill.

The Future

The Department is attempting to implement Public Law 93–641 at an unusually fast pace for a number of fundamental reasons, not the least of which is its commitment to the programs provided for in the statute and the urgency of the problems addressed by the law. There is a long lead time between initial implementation and actual operation of this complex and important program, and the Department can only begin to guess what kinds of operational problems will be encountered along the way.

Although the focus of this report is on the activities of the Federal Government, the major responsibility for implementing Public Law 93–641 rests primarily with the State and local organizations now being created. It is our hope that with the leadership of the State Governors, with the assistance of comprehensive health planning, regional medical program, and experimental health services delivery systems organizations, as well as with the support of local government, provider organizations, and consumers, that strong effective, representative, and credible health systems agencies will be formed. We also anticipate the need for effective State organizations. The Department will help in developing the framework, but the major impetus must come from the local level if we are to succeed.