Summary of the 1979 Health Planning Amendments

THE HEALTH PLANNING AND RESOURCES Development Amendments of 1979 (Public Law 96–79) authorize a total of $1.04 billion in appropriations for fiscal years 1980, 1981, and 1982. The law amends Title XV (National Health Planning and Development) and Title XVI (Health Resources Development) of the Public Health Service Act. For a summary of the changes in Title XVI, see p. 173. Following is a summary of the changes in Title XV.

National Guidelines, Priorities, Council

In revising or preparing new national guidelines, the Department of Health, Education, and Welfare (DHEW) must now solicit comments from health systems agencies (HSAs), State health planning and development agencies (SHPDAs), statewide health coordinating councils (SHCCs), and other organizations at least 45 days before initial publication of a new or revised guideline.

In addition, the goals and standards in the guidelines must be reviewed each year by DHEW, using local and State health plans as a basis for revision.

The Department may also collect data from HSAs and SHPDAs to determine whether health care delivery systems are meeting the goals contained in HSA and SHPDA health plans.

The guidelines and standards must reflect the "unique circumstances and needs of medically underserved populations in isolated rural communities."

Priorities expanded. The number of national health priorities in the law has been expanded from 11 to 17 while the overall theme of cost containment is strengthened and a new section is added on the role of competition in the allocation of health services. New priorities focus on:

• Identifying and discontinuing unneeded or duplicate services and facilities;

- Fostering cost containment through technology, efficiency, and more appropriate use of resources;
- Deinstitutionalizing improperly placed mental patients and improving needed institutional care;
- Emphasizing outpatient mental health care; and
- Promoting health prevention and treatment.

Added as a priority is the strengthening of competition where it can appropriately advance quality assurance, cost effectiveness, and access to care.

The law says Congress finds competition is "diminished" especially by third party payors, leading to duplication and an excess supply of certain health services and facilities.

The law directs health planning agencies to take actions to allocate the supply of services that competition does not appropriately allocate.

For health services for which competition appropriately allocates supply, consistent with the agency plan, agencies should take actions which will strengthen the effect of such competition.

National council. The new law increases membership of the National Council on Health Planning and Development from 15 to 20 persons. It adds the Agriculture Department's Assistant Secretary for Rural Development as a nonvoting, ex officio member. The number of consumer members rises from five to eight and at least one hospital representative must now belong to the Council. The law also requires urban and rural medically underserved areas to be represented.

Local Health Planning

Local planning operations are expected to undergo significant changes as a result of new authority to shift to a 3-year cycle for agency designations as well as plan development, a more liberal funding formula for HSAs, restrictions on the way governing body members are selected, more support for continuing education and training for governing body members, and approval of local health plans by the parent body in a public HSA. The amendments also call for changes in the plan development process and an easing of the restrictions on health service area redesignations.

3-year status. Agencies may receive full designation for up to 3 years at a time, although a nonperforming agency can be returned to conditional status for as long as a year following standard notice and hearing procedures.

Before renewing a full designation agreement, DHEW must give the State agency an opportunity to comment on the HSA's performance and make its recommendation on whether the agency should be returned to conditional status.

In terminating or renewing a nonperforming agency, DHEW must first consult with the State's Governor and SHCC and the National Council on Health Planning and Development, give notice, state steps that could be taken to come into compliance, and provide the HSA an opportunity for a hearing.

Funding. HSAs are now allowed to carry over unused funds for 1 additional fiscal year. Subject to actual appropriations, the funding formula is changed, with the maximum base grant set at the lesser of $.60 per capita or $3,750,000. The minimum base grant is $225,000 for fiscal year 1980, $245,000 for 1981, and $260,000 for each succeeding year. If the formula yields an amount not needed by the agency to perform its duties, the grant may be reduced by DHEW following a hearing.

DHEW is authorized to set aside 5 percent of appropriations to help HSAs facing "extraordinary expenses" resulting from such things as an interstate health service area, the development of innovative planning techniques, a large urban or rural medically underserved population, or a large service area.

Full implementation of this new authority is dependent on the availability of funds for the HSAs beyond what is needed to maintain the required per capita funding.

Non-Federal funds contributed to HSAs may be matched by the lesser of the amount of such funds or $200,000 or by $.25 per person in the area if that would yield more. For the first time minimally funded HSAs are eligible for additional Federal funding for non-Federal contributions (formerly matching), and these funds will now be awarded at the beginning of the fiscal year based on contributions to the agency during its previous fiscal year.

Lobbyist prohibited. New language in the law prohibits the use of HSA funds to pay a lobbyist, although money paid an agency employee is exempt as long as his primary responsibility is not to influence legislation.

This provision was designed to prohibit the hiring of a lobbyist and was not intended to alter the right of HSA staffs and board members to represent their agency's view before both executive and legislative branches.

Coordination. In an effort to provide stronger coordination within a health service area, the law gives examples of other administrative entities with which an HSA must coordinate its activities. Included are rate review boards, area agencies on aging, mental health planning agencies, and alcohol and drug abuse agencies. HSAs must also coordinate their activities with and seek to enter into agreements with Indian tribes in their area. All HSAs within a Standard Metropolitan Statistical Area are required to coordinate their activities, including coordination of plans, review criteria, and certificate of need decisions.

Selection of governing body. Congress shifted the focus of language dealing with consumer representation. The original language requiring consumers to be "broadly representative" of the various population groups has been dropped. The new wording says consumers must be "broadly representative of the health service area" and include representatives from the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area. This change is not intended to mandate a quota system but rather to give HSAs flexibility to adopt selection processes most appropriate to local needs.

The new law requires a consumer majority on all subcommittees or advisory bodies appointed by the HSA governing body or executive committee. No longer is a person required to have been a consumer for 12 months prior to an appointment as a consumer board member.

In an important change, the law now says a person will not be considered a provider solely because of membership on the governing board of a health care institution or drug or equipment producer.

Provider changes. Among the provider minority, which remains intact, the proportion of direct providers is increased from one-third to one-half and at least one person must be involved in hospital administration. Providers are now given the option of serving on governing bodies either where they live or where they work. In addition, podiatrists and physician assistants are added to the list of providers suggested for membership.

Except for elected officials, governmental representatives on governing bodies must be appointed by local government. In States with only one health service area, the State government makes the appointments.

The law says the percentage of nonmetropolitan representatives must "at least" equal the percentage of nonmetropolitan residents in the area's total population.

In keeping with a new emphasis on integrating mental health in the planning process, the bill requires that persons (consumers and providers) knowledgeable about mental health services (including substance abuse) be included on the governing body.

If required, the Veterans Administration representative is to be considered an ex officio governing body member without a vote and not counted in figuring board size. Hospital administrators, and persons knowledgeable about mental health services must be included, and the law lists labor organizations and business corporations as examples of major purchasers of health care, who must be included.

Volunteer support. Each HSA is now required to have an "identifiable" program of support and assistance to members of the governing body, executive committees, and subcommittees appointed by the HSA. The program must define their needs and provide the necessary "support, training and continuing education." In addition, at least one staff member must be designated to provide governing body members, especially consumers, with information and technical assistance. In a revision of reimbursement policy, the law authorizes cash advances to board members for costs incurred in attending meetings and performing other needed functions of the agency.

Liability clarified. The liability issue has been clarified. An HSA is protected from paying damages in State and Federal court when a governing body member or employee acts within the scope of his duty with reasonable care and without "gross negligence or malice."

To prevent governing body "self-perpetuation," the law requires that local residents have an opportunity for broad participation in selecting new members. Each HSA is given the responsibility of encouraging and developing this involvement. The law requires at least half of each governing body be selected by means not involving existing governing board members.

The same standards apply to subarea councils if the council selects one or more members of the governing body. (For public HSAs, the law requires the governing board to appoint governing body members.)

A governing body with more than 30 members must now have between 10 and 30 members on its executive committee.

Conflicts of interest. A new section deals with conflict of interest for members of governing bodies, executive committees, or other HSA entities. Individuals are prohibited from voting on matters involving any individual or organization with which the member has had "any substantial ownership, employment, medical staff, fiduciary, contractual, creditor, or consultative relationship" currently or during the past 12 months. Written disclosure and public announcement of conflicts are required at meetings during which action is taken. These standards also apply to statewide health coordinating council members.

Open meeting provisions were changed to allow closed meetings and records when the board determines that discussions about an employee's performance or salary would clearly constitute an unwarranted invasion of personal privacy. Meetings also may be closed when information relating to an agency's judicial proceeding might be disclosed.

Public HSA. The governing board of a public HSA will appoint the members of its governing body. The governing body is responsible for the budget and personnel policies unless it specifically delegates the responsibility.

If the governing body of a public HSA does not accept additions or revisions of the health systems plan proposed by the governing board during review, the rejected suggestions must be attached to the plan. Four HSAs which were units of local government before January 1, 1979, have the right to *approve* the plan.

Health plan development. The health systems plan (HSP) may now be revised by the HSA and reviewed by the statewide health coordinating council every third year, reducing paperwork and allowing more time to be spent actually implementing plans. The goals of the HSP are to be responsive to statewide needs identified by the State agency. Both the health systems and State health plans must specifically describe the institutional health services needed to provide for the well-being of persons in the area. The health systems plan must describe the number and type of resources needed to meet its goals. It must also state the extent to which new facilities need to be constructed or existing ones need to be modernized, converted, or closed.

Goals for delivery of mental health services must be included after consultation with a knowledgeable advisory group.

The SHCC is required to establish a uniform plan format which each HSA must follow.

The requirement that goals in the plan be consistent with the National Guidelines for Health Planning has been dropped, although a detailed list of reasons must be sent to the State health planning and development agency, the statewide health coordinating council, and DHEW, telling why the plan varies from the guidelines.

The requirement that the HSP include a description of a "healthful environment" is now to be "primarily with regard to health care equipment and to health services provided by health care institutions, health care facilities and other providers of health care and other health resources."

The law now requires that establishment, review, and amendment of the annual implementation plan (AIP) follow the same process set up for the HSP, including public notice and hearing.

Publication of hospital charges. To aid consumers in making informed choices, a new provision requires each HSA to collect and make public yearly the charges for the State's 25 most frequently used hospital services. The list must include average rates for private and semiprivate rooms. The information will be made available in a manner that enables the public to make comparisons.

Service area changes. The process for reviewing and revising health service area boundaries has been changed in the new law. A review can now begin on the initiative of DHEW, an HSA, or any State Governor. DHEW must revise boundaries if they are found to no longer meet the law's requirements and if proposed boundaries would be significantly more efficient and effective for health planning efforts.

HSA staff must now also have expertise in financial and economic analysis, mental health, and disease prevention.

State Health Planning

The amendments contain provisions expanding designation periods and duties of State planning agencies, and improving the composition and authority of statewide health coordinating councils.

Under the new law, composition of the SHCC will depend on the number of health systems agencies in the State. In States with 10 or fewer HSAs, each agency will have 2 representatives; if there are more than 10 HSAs, each will have 1 representative. Nominations are made by each HSA that sends the Governor a list of at least twice as many representatives as it is entitled to. Interstate HSAs are assured at least one SHCC representative and possibly more, depending on a population formula. At least one-half of the providers on the SHCC must now be direct providers.

Urban and rural medically underserved populations in a State are to be represented on the SHCC, as is the Veterans Administration if the State has one VA facility, although that representative is an ex officio and nonvoting member.

The Governor is given the option of selecting, with legislative advice and consent, the SHCC chairperson from among its members. If the Governor decides not to act, the SHCC can choose its own chairperson.

SHCC responsibilities. The law gives the SHCC new responsibility to establish, after consultation with HSAs and the State health planning and development agency, a uniform format for the health systems plan. Like the SHPDA, the SHCC must also review HSPs at least every 3 years and annual implementation plans every year.

In developing a State health plan the SHCC must include a description of the institutional health services needed in the State, as well as the number and type of resources available and those in need of modernization, closure, and conversion. The SHCC is given authority to review and make a recommendation on certain applications by the State government for Federal funds to be used in more than one health service area. The law extends to SHCC members the same liability protection and conflict of interest requirements outlined for HSAs.

State agencies. As with HSAs, State planning agencies may now receive full designation agreements lasting up to 3 years. For conditional SHPDAs, DHEW has been given authority to extend their life beyond 3 years if the agency is making a "good faith effort" to meet the law's requirements. A fully designated SHPDA which is not performing satisfactorily also may be returned to conditional status for up to a year.

The penalties for a State failing to have its agency qualify for full designation have been extensively revised and the effective dates changed. During the first year of noncompliance, DHEW will withhold one-quarter of certain Federal funds, with the percentage rising to one-half the second year, three-fourths the third, and a complete cutoff the fourth year. September 30, 1980, is the earliest date for compliance, but the deadline will be later for many States, depending on when their legislatures meet.

Agency renewal. Before renewing a State agency's designation, each HSA and the SHCC must be given the opportunity to comment and make their recommendation on the renewal. In terminating a SHPDA, DHEW must follow procedures similar to those dealing with HSAs involving consultation with the SHCC and the National Council on Health Planning, giving notice, detailing corrective action required, and providing a hearing opportunity.

The determination of statewide health needs is a new job given to the State agency under the law. In developing this list, the SHPDA must seek written recommendations from the State health authority, other agencies designated by the Governor, and the SHCC. The law also calls for the SHPDAs to make an inventory of health care facilities along with an evaluation of their physical condition. This change and others are intended to allow use of the plan for State medical facilities planning. The inventory will also be given to the HSAs for use in their planning activities.

The bill also specifically requires that the mental health, drug abuse, and alcoholism plans be consistent with the State health plan.

Like HSAs, SHPDAs may now carry over unused funds for 1 year.

Development of the preliminary State health plan and review of health systems plans may now be conducted on a 3-year basis, while the yearly review of the AIP remains. The State plan must be approved by the SHCC and then the Governor before it takes effect. The Governor can reject the plan only if he feels it is not effective in meeting the statewide health needs.

The State agency must refer the health systems plans to the State mental health authority and other agencies

of State government designated by the Governor to review the goals and related resource requirements of the plans. These agencies, in turn, must make written recommendations to the SHPDA regarding the goals and requirements. If the SHPDA does not take one of the actions proposed in a recommendation submitted under this procedure, the agency must make a written statement of its reasons available to the public.

Certificate of Need Program

The certificate of need (CON) program, its focus expanded in the new law, now requires a State certificate of need program to cover major equipment serving inpatients regardless of the equipment's location.

Other changes now give State agencies authority to withdraw approved certificates and issue exemptions for certain health maintenance organizations.

State programs are not required to cover equipment in independent clinical laboratories or physicians' offices, although they may if provisions are already in State law or will be by September 30, 1982.

The law limits the type of conditions that can be placed on the awarding of a CON. States are prohibited from attaching any condition not related directly to criteria in the law, in Federal regulations in place before the new law took effect, or State law.

Besides dealing with the granting of certificates, the law also contains provisions for taking them away. Applicants will be required to specify a timetable to be followed in making the new service or equipment available to the public.

After issuing its certificate, the State health planning and development agency will be responsible for following the applicant's progress in meeting the timetable. If the applicant is not adhering to the schedule or making a good faith effort to complete the project, the certificate can be withdrawn. Each certificate must now specify the maximum amount of money that can be spent on an approved project, and it will be up to each State to develop a review process if the targeted amount is exceeded.

Batching. "Batched reviews" are now required for certificate of need applications at both the State agency and health systems agency at least twice a year. With batching, an agency reviews groups, or batches, of similar applications at the same time. This scheduling process, begun recently in New York State, allows any proposal to be judged in comparison with the others.

HMO exemptions. Major changes relate to health maintenance organizations (HMOs), as defined in the law. States are now prohibited from requiring certificate of need coverage of inpatient services, acquisition of major equipment, or of capital expenditures by health maintenance organizations if an HMO, or combination of HMOs, meet certain conditions.

The HMO must meet the definition under Title XIII of the Public Health Service Act or under the new CON provisions in the law. Further:

- It must have at least 50,000 persons enrolled,
- The facility must be in a location reasonably accessible for the enrollees, and
- At least 75 percent of the patients expected to receive the service must be enrolled in the HMO.

The establishment of a new HMO and its outpatient activities are also exempt.

To qualify for all exemptions, HMOs must apply for State approval, submitting information to prove the organization meets the conditions for exemption outlined in the law.

CON applications from nonexempt HMOs must be approved if the State agency finds that approval is required to meet the needs of enrollees and the HMO cannot obtain these services or facilities within the area in a manner consistent with the HMO concept.

Automatic approval. The new law requires automatic approval of any certificate of need application to comply with building and life safety codes, State licensure standards, or Medicare and Medicaid certification unless the SHPDA finds that the services are unneeded or at odds with the State health plan. Simple acquisitions of health facilities or major medical equipment for noninstitutional use are also given special treatment in the legislation. In both cases, a notice stating intent to acquire and expected uses must be filed with the SHPDA 30 days before contracts are signed.

These acquisitions are exempt from certificate of need coverage unless notice is not given or if the action will provide inappropriate bed capacity or services.

There are significant additional requirements to assure due process, including requirements for administrative and judicial reviews of adverse certificate of need decisions and requirements that the State agency must make a finding within a period which the State agency must establish.