PART 2
HEALTH PLANNING AND RESOURCES
DEVELOPMENT AMENDMENTS OF 1978

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT
OF THE
COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES
NINETY-FIFTH CONGRESS
SECOND SESSION
ON
H.R. 10460
A BILL TO AMEND TITLES XV AND XVI OF THE PUBLIC
HEALTH SERVICE ACT TO REVISE AND EXTEND THE AU-
THORITIES AND REQUIREMENTS UNDER THOSE TITLES FOR
HEALTH PLANNING AND HEALTH RESOURCES DEVELOPMENT

JANUARY 30, 31, FEBRUARY 1, AND 2, 1978

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  Johnson, Gifford, president.

American Dental Association:
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  Kerr, I. Lawrence, D.D.S., member, board of trustees.

American Federation of Labor and Congress of Industrial Organizations:
  McLotten, Robert, legislative representative, department of legislation.
  Siedman, Bert, director, department of social security.
  Shoemaker, Richard, assistant director, department of social security.

American Health Planning Association:
  Hanson, Jacqueline B., treasurer.
  Matek, Stanley J.

American Hospital Association:
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American Medical Association:
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   Meyer, Dave, executive director.
HEALTH PLANNING AND RESOURCES DEVELOPMENT
AMENDMENTS OF 1978

THURSDAY, FEBRUARY 2, 1978

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met pursuant to notice at 10:45 a.m., in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. Rogers. The subcommittee will come to order, please.

We are continuing hearings on the Health Planning and Resource Development Amendments of 1978.

We are pleased to have as our first witness the Honorable Arlan Stangeland from Minnesota who is very much interested in this matter.

We welcome you and your statement will be made a part of the record, and you may proceed as you desire.

STATEMENT OF HON. ARLAN STANGELAND, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. Stangeland. Thank you, Mr. Chairman. I appreciate the opportunity to speak before you this morning on the revised extension and amendment of the Health Planning and Resources Development Act. We all know that Government moves slowly, but it is 1978 and we are just now beginning to implement fully the provisions of this legislation which was initially enacted in 1974. Therefore, let me preface my remarks with the fact that we obviously need to extend the law and we definitely need to amend it.

My primary concern is the small rural hospital. I represent the seventh district of Minnesota which has approximately 300 small towns and covers over 60,000 square miles. In this sparsely populated area, the continued existence of small hospitals is vital.

As we all know, the Department of Health, Education and Welfare last September issued proposed health planning guidelines which imposed unrealistic requirements on rural hospitals. I do appreciate the Department's response to the outpouring of comments on these proposed guidelines. As a result of more than 55,000 communications received by the Department—54,000 of which seemed to have arrived in my office—it has recently revised the guidelines to allow a good deal of discretion for local health systems agencies in determining the accessibility of hospital care [see p. 882].

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The point I wish to make is that a lot of time, worry and bureaucratic procedure could have been avoided if the law itself explicitly states that such local discretion would be granted.

As you know, we will soon be considering the Postal Service subsidy legislation. I think that we must realize what a large part the Government itself plays in creating the need for a subsidy in placing an often unnecessary burden on this public service. Fifty-five thousand pieces of mail could possibly have been eliminated by doing some homework prior to issuing regulations and guidelines. The Federal Government must begin somewhere to eliminate red tape and return control of their lives to the citizens themselves.

It is my understanding that the recent guidelines are the first in a series of such proposals. We now have the opportunity to experiment in good Government by allowing local communities to decide how their needs may best be met. Instead of solving each situation with an ad hoc solution, we should determine beforehand what the policy will be—and I urge that it be local input and control.

Of course, we all recognize the need to reduce health care costs. I would like to point out that Federal control does not necessarily insure reduced costs nor better service. Two small hospitals in my district, which seem to be representative, have records of which I am proud. In Aitkin County, whose population is approximately 12,000, the average cost for 1977 for a day's hospitalization was $121 and the average length of stay was 5.9 days. Another community hospital in Warren, which serves a county of 14,000 managed to provide hospital care last year for $109 per patient day and kept its patients a little over 5 days per average stay. This compares with a national average of approximately $170 per day and an average stay of more than 8 days.

During your deliberations on the proposed changes to this legislation, I most earnestly request that you approve language which formalizes the concept of local control by explicitly stating that local health systems agencies and the communities which they represent will be given all possible discretion in the administration of health care planning. By imposing guidelines from above, even though they may later be revised to allow more flexibility, we automatically implant in the minds of the local Health Systems Agencies the idea that they must meet these requirements. What we actually need is initial input from the affected communities who are free to express their ideas without any fear of coercion on the part of the Federal Government. We should start from the bottom up. Rather than proposing rigid and unrealistic guidelines, a little effort spent in consulting with local communities regarding their particular needs and requirements could eliminate a mass of communications, confusion and misunderstandings.

In concluding, I would like to mention that here in Washington, with our immediate access to the finest health care available, we possibly do not realize the effect which proposals, such as those initially passed, can have on a small, rather isolated community. In Minnesota we have long, hard winters and we work hard in often physically demanding and hazardous occupations. The comfort de-
rived from the knowledge that health care is available and that medical emergencies can be dealt with does not have a price tag. I was particularly concerned over the many letters which I received from the elderly population in my District. In our area older people who retire from the farm tend to concentrate in these small communities which the hospitals serve. A real, everyday concern to them is the availability of health care.

I cannot emphasize too greatly the need to assure that these small hospitals are preserved. From their record of cost efficiency, I do not think we are granting any favors. Indeed, we may wish to consult with them to benefit from their experience.

That is the end of my testimony, Mr. Chairman.
If there are any questions, I would be happy to attempt to respond.
[Testimony resumes on p. 906.]
[The following letters were received for the record:]
The Honorable Paul G. Rogers  
Chairman  
Subcommittee on Health and the Environment  
Committee on Interstate and Foreign Commerce  
U. S. House of Representatives  
Washington, D. C. 20515  

Dear Mr. Chairman:

I would very much appreciate your including the enclosed material as a part of the official record on the proposed extension and amendment of the Health Planning and Resources Development Act.

Thank you for your attention in this matter.

With best regards, I am

Sincerely,

Arlan Stangeland  
Member of Congress

Encl
The Honorable Arlan Stangeland  
House of Representatives  
1518 Longworth House Office Building  
Washington, D.C. 20515

RE: Amendments to and Extension of P.L. 93-641

Dear Mr. Stangeland:

As a member of the Seventh District’s Health Care Advisory Committee, I have been requested by Mr. Mark Wedel to comment on the upcoming hearings of the House Subcommittee on Health and the Environment, which will consider proposed amendments to and the extension of P.L. 93-641. Due to the relatively short time we have in which to respond to your request for information, my comments will be somewhat brief and general.

The Bemidji Community Hospital, which is a member of the Minnesota Hospital Association (MHA), concurs with MHA in its strong support of the population-based comprehensive health planning process established in P.L. 93-641. Since the Health Systems Agencies (HSAs) are in the best position to evaluate the needs and demands of their constituents, we endorse MHA’s position to have the planning process begin at the local HSA level. We request that the proposed amendments give the authority for planning to the local HSAs and permit the continued representation of our hospitals and nursing homes on the HSA board.

Section 1513b (2) currently directs the local HSAs to develop plans that are "responsive to the needs and resources of the area" within a framework of state and national priorities. We hope that Congress will continue with this language, which allows the local HSA to develop its own plan. We further hope that Congress will give directives to the Department of Health Education and Welfare which will permit the HSAs to develop their plans in the best manner they deem necessary. With the tremendous number of negative responses to the National Guidelines proposed in September 1977, it is clear that the health care industry has gone on record to support health planning at the local level and not at the federal agency level.

If the Certificate of Need law requirements under P.L. 93-641 are to achieve the expected goal of reducing expensive duplication, the law must be expanded to include all health care providers and the now-exempt federal

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*An equal opportunity employer*
facilities, i.e., Veterans Hospitals and P.H.S. Hospitals. Currently federal facilities must be represented on HSA boards, but are not included under the law.

The task before our HSAs is formidable indeed. If they are to be at all successful in their endeavors, Congress must give them the authority or means by which to obtain adequate funds. The HSAs should be permitted, therefore, to seek funds from non-governmental sources.

We again welcome this opportunity to express our opinions to you for your consideration.

Best regards,

James W. Maki
Assistant Administrator

cc: J. Mark Wedel, Chairman
    Health Care Advisory Committee
    Minnesota Hospital Association
Red Lake Falls, MN 56750
February 1, 1978

The Honorable Arlan Stangeland
House of Representatives
Washington, D.C. 20515

Dear Mr. Stangeland:

I am writing in regard to Public Law 99-641 which is currently in public hearing. I serve on the board of directors of an area health systems agency. In this capacity I have seen the need for rural HSAs to function as a means of controlling facilities and placement of health care. This letter is a request for increased minimum funding. It is interesting to note that a law has been enacted for HSAs, yet it is very difficult to receive the proper level of funding. With the large rural area that our HSA serves, the costs are significantly higher than in some of the metro areas because of distance in accessibility of areas, etc. Therefore, I would very much appreciate an increase in minimum funding if we are to have this kind of health systems agency concept.

Sincerely,

Jean Hanson

mca
January 30, 1978
Re: Funding of RSA's under PL 93-641

Representative Alan Stangland
Box 726
Detroit Lakes, MN 56501

Dear Representative Stangland:

I write to you both as a Board member of the Agassiz Health Systems Agency and as a hospital administrator in the area concerned.

I ask you to consider input into the hearings now being held on PL 93-641 for increased minimum funding for RSA's. In addition, I ask that consideration be given to funding the Area Health Services Development Fund - congressionally authorized but never funded.

My reasons are:

1. While all RSA's must perform the same functions, rural RSA's usually do not have the same funding capabilities as metro RSA's.
   a. Last year Agassiz found it necessary to use $10,000 of local funds; this year about $20,000 over minimum funding and next year there will be little or none - which means a reduction in staff, already at minimum.
   b. Although I believe the law intended matching funds based on population but we have not been able to apply for this because of our population base (314,000 in 27,000 square miles).

Additionally it would seem appropriate to consider additional funding for bi or multiple state agencies because additional costs are incurred.

1. We have a large area to cover - both for staff, Board and Committees.
2. We must meet with SHPDA's in two states in order to arrive at common development and implementation plans - no small task with different viewpoints with which to contend.

In order for Agassiz and other rural RSA's to remain viable it is imperative that:

1. Minimum RSA funding be increased to at least $225,000.
2. Some change be made to allowing matching funds based on a different population formula.
3. Additional funding be made available for those RSA's which cross state or regional lines.
Your serious consideration of these matters will be most appreciated.

Very sincerely yours,

Fred Shrimpton

cc: Donald E. De Mars
    Executive Director
    Agassiz Health Systems Agency

Note: I agree upon the hoofprint in the report
I am interested in this
but had a test must be paid.
December 28, 1977

Honorable Arlan Stangeland
4th Floor, FM Center
403 Center Avenue
Moorhead, MN 56560

Dear Congressman Stangeland:

I first want to wish you a warm holiday season and tell you how much I enjoyed visiting with you at the Chamber of Commerce offices in East Grand Forks. (I'm the Councilman who told you the train slowed down so people could wave at you.)

I did mention that I would be getting back to you because of the expected changes pending in the Health Planning and Resources Development Act - P.L. 93-641.

There are some changes our agency would like to see in the law, and I will get back to you detailing out changes necessary to assist health planning in our rural area of Northeast North Dakota and Northwest Minnesota.

The most critical issue we face at this time is the need for a higher minimum funding level for our rural Health Systems Agencies.

We are expected, in fact we are required, to perform the same functions as any large metropolitan based health systems agency.

I do not particularly desire large federal handouts to accomplish those things we can do at a local level, but P.L. 93-641 is a good federal strategy to give local planning areas an opportunity to plan and determine the services we want and need.

As the attached letter documents, without a higher minimum funding level our agency will go belly-up.

If there is anything (information, visits, etc.) I can do to assist you in this endeavor please call on me. My Board of Directors (of
64 - representing consumers, providers, and elected officials of your district) has encouraged this contact, and I am writing this letter with their support.

Again thanks for a pleasant evening, and I look forward to your response and help.

Sincerely,

Donald E. DeMers
Executive Director

Enclosure
December 12, 1977

Mr. Bernardo Benes, President
American Health Planning Association
2560 Huntington Avenue, Suite 305
Alexandria, VA 22303

Dear President Benes:

I am writing this letter to share with you the deep concern our agency has for its very survival. Our bi-state health systems agency of 27,000 square miles and 314,000 citizens under present funding levels will soon not be able to function.

If I may note some of our budgeting concerns:

1. Last year our agency received only $145,000 and we had to spend $10,000 hard earned local monies.

2. This year our agency will have to spend $15-20,000 over the minimum funding of $175,000.

3. Next year will reduce any local monies we have to about zero; and if there is no increase in the minimum grant I will be forced to let go staff (a catch 22 since I'm supposed to have five professional staff).

4. To compound matters - because of our population base we have not been allowed to match for monies over the $175,000 --- a process I believe was intended.

Rural Health Systems Agencies must perform the same major 18 regulated functions as any metropolitan HSA. They usually can only afford five professionals (and they must compete with adequate salaries). Rural HSA's also attempt to retain their staff longer (we can't afford a 20% turnover regularly) and this contributes to salary increases etc.

For the above noted reasons, I implore you to have your legislative committee recommend minimum funding levels of $225,000 to $250,000 to Congress.
Our agency has been a dues paying member of AACHP now AHPA since its inception. I hope to be able to continue to support AHPA—but we need your help.

I additionally request that AHPA consider supplemental funding for bi-state agencies. We do incur additional costs as the following summary notes:

1. We have had to have extra meetings in Minnesota and North Dakota with SHPDA's to arrive at a common plan development process.

2. Our rural area covers over 27,000 square miles—we have to get out in the field.

3. Time/distance costs for my Board are obviously compounded.

4. Review activities have necessitated extra meetings on 1122 and Certificate of Need (especially in developing new legislation).

5. There is a time loss factor of my minimum staff of five having to be gone so often.

6. Because of the newness and confusion of the legislation we've had significant pressure to attend technical assistance meetings.

7. It is imperative to note, that every agency (regardless of staff size) must meet all of the major items noted in the law and regulations—not including all the other activities attendant on an HSA.

I appreciate AHPA, and I appreciated your comments at last June's annual meeting. I believe AHPA has the credibility to affect congressional decisions. Anything you can do will be appreciated.

Sincerely,

Donald E. Demers
Executive Director

cc: Frank Armstrom
    S.E. Colorado HSA
    Member AHPA Legislative Committee
I. INTRODUCTION

A. Rural and minimally funded Health Systems Agencies support the concepts and Congressional intent behind Public Law 93-641 "The National Health Planning and Resources Development Act of 1974." P.L. 93-641 has consolidated efforts from competing Federal programs, improved and built upon the successes and failure of those programs, and extended the concept and functional viability of health planning to the entire country. Among the 200+ Health Systems Agencies across the nation are many small but tenacious organizations grappling with the problems of quality health services, adequate availability and accessibility, while attempting to meet necessary cost containment goals. The following agencies comprise this dedicated group of consumers, providers, and professional staff actively implementing this Law.

West Alabama Health Council, Inc.
Gladsden Alabama Health Systems Agency
Southeast Alaska Health Systems Agency
South Central Health Planning & Development of Anchorage, Alaska
Northern Alaska Health Resources Association
Navajo Health Systems Agency
Arkansas Health Systems Agency
South Arkansas Health Systems Agency
North Bay Health Systems Agency of Napa, California
Region 9 H.S.A. of Crest Hill, Illinois
Tiloua Health Systems Agency
Health Planning Association of Western Kansas
Western Maryland Health Systems Agency
Health Planning Council of Eastern Shore, Cambridge, Maryland
Merrimack Valley Health Planning Council of Lawrence, Massachusetts
Northern Michigan Health Systems Agency
Upper Peninsula Health Systems Agency, Marquette, Michigan
H.S.A. of Western Lake Superior of Duluth, Minnesota
Central Minnesota Health Systems Agency
Southeastern Minnesota Health Systems Agency
Missouri Area 5 H.S.A. Council
Southeast Nebraska Health Systems Agency
Greater Nevada Health Systems Agency
Health Systems Agency of Clark County of Las Vegas, Nevada
NY-Penn Health Systems Agency
Western North Dakota Health Systems Agency
Agassiz Health Planning Council, East Grand Forks, Minnesota
West Central Ohio Health Systems Agency
Eastern Oregon Health Systems Agency
Keystone Health Systems Agency of Altoona, Pennsylvania
West Tennessee Health Association
Panhandle Health Systems Agency, Amarillo, Texas
South Plains Health Systems Agency of Lubbock, Texas
West Texas Health Systems Agency, El Paso, Texas
Pecos Basin Regional Planning Commission of Midland, Texas
Southwest Washington Health Systems Agency
Central Washington Health Systems Agency
Eastern Washington Health Systems Agency
Lake Winnebago Area Health Systems Agency of Oshkosh, Wisconsin
New Health Systems Agency of Green Bay, Wisconsin
North Central Area Health Planning Association of Wausau, Wisconsin
Wyoming Health Systems Agency
Western Colorado Health Systems Agency

B. In facing the serious challenges of P.L. 93-641, the foregoing group has
had to struggle not only with the problems indigenous to their areas,
conflicting and confusing Department of Health, Education, and Welfare
regulations, performance standards criteria and guidelines, but also a
serious and crippling lack of adequate funding. Furthermore, many of these
agencies serve sparsely populated and immense geographic areas, often with
rugged terrain, adverse weather and limited transportation networks.

Congress has mandated enormous responsibilities for all Health Systems
Agencies throughout the country, regardless of their size. However,
current funding, which is based primarily on a per capita dollar formula,
often penalizes smaller agencies in meeting the health needs of their
residents. Notwithstanding the challenges faced, these agencies have had
notable successes, not only in meeting Federal guidelines and expectations,
but also community needs, in the short timeframe of less than two years.
II. FUNDING PROBLEMS

A. A listing of activities mandated by Congress which each Health Systems Agency is required to perform is found in Attachment 1. This list also includes performance standards and expectation levels developed by the Department of Health, Education, and Welfare as a basis for measuring Agency compliance.

It is apparent from this list of activities that the responsibilities of all Health Systems Agencies are enormous. Where this affects the small, minimally funded, and rural Health Systems Agencies to a greater extent is in the capacity to meet these standards with limited staff and resources.

Results of a survey recently taken with respect to the needs of these agencies in meeting the above standards have clearly indicated that, under current funding levels, most of these agencies do not have more than five professional and two clerical staff. The Bureau of Health Planning and Resources Development (BHRPD) currently requires agencies to maintain records and activities in seven distinct functional areas:

- Agency Management
- Plan Development
- Plan Implementation/Project Review
- Plan Implementation/Resources Development
- Data Management
- Coordination
- Public Involvement

Most agencies surveyed estimate that, in order to adequately meet current expectations, a minimum or average of one staff member per function is a prerequisite. Further, many feel that additional staff is necessary to comply with local needs and demands.
It should be noted that Congress has established a minimal funding level of $175,000 in P.L. 93-641 to accomplish all of these tasks. Unfortunately, the Department of Health, Education, and Welfare interpretation has, for the most part, concluded that this is the maximal funding level for most of the agencies previously listed.

The group asked that the minimal Federal funding level be at least 70c per capita with a minimum of $275,000, including a provision for inflation. Further, the group feels that the Secretary of the Department of Health, Education, and Welfare should be given 5% of the appropriation made under this Act for discretionary use. The Secretary would then have the ability to meet the needs of those agencies which have extraordinary travel needs caused by large geographic areas and/or sparse or widely distributed population, energy, or other growth impacts, multiple jurisdictions such as two state agencies or SWCCS, and other problems.

B. The agencies presenting this testimony extend across the Nation, North and South, East and West. Many face, as previously indicated, enormous distances, sparse population, difficult terrain, and significant adverse weather conditions. Public Law 93-641 demands public involvement of consumers and providers who are residents of the area in planning for their health. For issues to be discussed and resolved in a democratic manner, adequate provision must be made for insuring participation, involvement, and accountability by and with health service area residents. From the survey, many of the small agencies spend in excess of 10% of their total budgets in Board, Committee and Staff Travel.

(Add Examples)
Involving the public in crucial health planning decisions is, perhaps one of the few rational approaches to the overall cost containment in health services. Comparing agencies covering 40,000 square miles and spending fifteen percent of their budget on travel with those of 400 square miles and spending less than five percent, is a major point that Congress should review and consider after the Oversight Hearings are conducted.

III. RURAL PROBLEMS

A. Previous Congressional Reports such as The Economic and Social Condition of Rural America in the 1970's (prepared by the United States Department of Agriculture, December 1971) have found that rural Americans do not share proportionately in programs funded by the Federal Government. Federal spending on Human Resource Development (Education, Health, Welfare, Vocational Rehabilitation, Manpower Training and Development) favors metropolitan counties over rural areas.
Examples are as follows:

- per capita outlays under conditions of pronounced population decline for health services are 4 times greater -- welfare payments 4 times greater -- manpower training and development 3 times greater -- in metropolitan counties than in rural ones;

- rural counties account for 66% of all substandard housing units but receive only 16% of all Federal housing assistance;

- rural counties account for 50% of all children between the ages of 6 and 17 in poverty level families, but receive only 20% of all Federal child welfare service funds -- 24% of Federal aid to families with dependent children -- 26% of Federal Headstart and followthrough assistance; and 41% of Federal outlays for elementary and secondary educational programs aimed at meeting the specific needs of disadvantaged children in low income areas.

The entire history of Federal support for local regional health planning has been one of underfunding for rural areas. While 27% of Americans live in rural areas, only 15 to 20% of the health planning money went to the rural areas. Comprehensive health planning for rural areas tended to be done by the State agency rather than by an areawide rural health planning agency.

Although the present health planning legislation provides for total geographical coverage by Health Systems Agencies and a minimum funding level of $175,000 for less populous agencies, we suggest that health planning in rural areas remains underfunded. A large part of the work of the rural Health Systems Agency is in the Plan Implementation/ Resources Development function, in addition to being concerned with some cost containment issues relating to inappropriate service development.

This commitment to resource development should be evident from the correlation between "Critical Health Manpower Shortage Areas" (CHMSA) and "Medical Underserved Areas" (MUA) and the areas covered by rural Health Systems Agencies. Furthermore, the need for making health services
more available and accessible in rural areas has been recognized by
Congress, as evidenced by item (1) of the "National Health Priorities of
P.L. 93-641:

"Sec. 1502. The Congress finds that 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 planning and resources development
programs:

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

Because of the added challenge of resource development (in addition to
other problems noted previously), we submit that rural Health Systems
Agencies should be funded higher than urban areas. This proposition is
as reasonable and logical as understanding that per capita public
assistance payments (and many other Federal spending programs) will
always be higher in urban areas and attempting a rural-urban equalization
for income maintenance (and many other programs) would not be feasible.

Increasing the minimum funding base for rural Health Systems Agencies will
not only strengthen the implementation of P.L. 93-641 in approximately 40% of
the area of the Nation, but it will help to provide necessary resources
to planning agencies attempting to ensure the most effective and efficient
utilization of resources. Adequate financial support is essential for
effective rural health planning which is a requisite for assuring that
health care services are available, accessible, and acceptable for all
residents of rural areas.

B. Historically, Federal approaches to health problems have been categorical;
most programs have focused on individual groups or populations with
specific problems or diseases or special beneficiary status. While we
understand there are complex pros and cons concerning categorical programs
vs. block formula grants and the revenue sharing approach, the dominance
of categorical programs places a great burden on Health Systems Agencies, especially minimally funded agencies with few staff resources. Health Systems Agency staff must become familiar with hundreds of programs and dozens of personnel in several departments in order to plan and develop resources consistent with legal and other constraints within which these programs must operate. Again, the rural Health Systems Agencies require additional resources in order to relate properly and effectively with Public Health Service Program Chiefs to assure that the allocation of Federal categorical funds are consistent with the Health Systems Plans (HSPs) of Health Systems Agencies. The establishment of these important relationships are obviously more difficult for agencies with severely limited staff resources.

C. Although P.L. 93-641 was very successful in consolidating the Regional Medical Programs, Comprehensive Health Planning and Health Service Demonstration Projects, there still remains fragmentation of health planning efforts in most health service areas. Planning for implementation of Emergency Medical Service is an example. The insulation of the Federal Veterans Administration and their own internal planning is another. Furthermore, there are many state efforts (often with Federal support) that further fragment health planning in rural areas.

More recognition and support on the part of all Departments and Programs of the Federal and state governments could go a long way to assist rural health planning agencies in acquiring the critical mass necessary to accomplish their planning and development responsibilities.

D. There are great difficulties for rural Health Systems Agencies in developing an adequate data base. There are a number of factors contributing to this problem. Among them are insufficient assistance
from the Department of Health, Education, and Welfare and most State Health Departments and State Health Planning Department Agencies with present legal restrictions on the collection of primary data in the absence of assistance from other sources. Rural Health Systems Agencies are also dependent upon data from health care providers, such as small rural hospitals, who often do not keep records on such items as discharge diagnosis or, in cases where they do, they are often not uniform with other hospitals in the area. In addition, Health Systems Agencies are held accountable for cost containment but the Federal and State Governments do not disclose or provide adequate financial information that is routinely provided by health care provider groups.

E. Another concern of the rural Health Systems Agencies are the recently proposed and revised Department of Health, Education, and Welfare Guidelines for Health Planning. The group supports the need for a balanced approach which includes strong health planning, appropriate health service development, and regulation. The group supports active participation in the development of cost containment strategies that accurately reflect the unique needs of their Health Service Area residents. It should be recognized that the Guidelines are useful in establishing debate and focusing concern on necessary cost containment initiatives. It should be remembered that the Guidelines are, in fact, only experimental estimates which should serve as guidance but not Law.

IV. RURAL HEALTH PLANNING SUCCESSES

A. Despite the problems, limitations, and constraints under which rural Health Systems Agencies must operate, they have experienced some rather
significant successes. Attached are the positive experiences of rural Health Systems Agencies. Their activities are categorized as Resource Development Successes and Cost-Containment Successes.

(Add Examples from Attachment 2)
AGENCY ORGANIZATION AND MANAGEMENT

Establish policies for organization structure, governance, and operation of Agency.

Ensure public notice of all HSA activities and meetings.

Develop and monitor work program and budget.

Establish and maintain internal management reporting system.

Establish and maintain financial administration system.

Develop personnel policies and procedures.

Develop and maintain on an ongoing basis training programs for the Governing Body, staff, committees, Subarea Advisory Councils, etc.

Maintain staff which meets the requirements of the Law.

Main Governing Board which meets the requirements of the Law.

PLAN DEVELOPMENT

Coordinate planning with Federal, state, and local agencies and organizations.

Conduct public hearings on the H.S.P.

Publish and disseminate HSP to area libraries, the SHPDA, SHCC, and other state and local agencies.

Conduct Annual Review of HSP.

Establish procedures and process for Annual Review.

Involve the community in the development of the HSP.

Develop Annual Implementation Plan to describe objectives and priorities to achieve the goals of the HSP.

Ensure notice of AIP availability.

Publish and disseminate AIP to area libraries, SHCC, SHPDA, and other state and local agencies.

Review AIP annually and amend, as necessary.

Identify, collect, and analyze pertinent data
  - health status
  - health system

Establish goals and priorities in the HSP.
PLAN DEVELOPMENT CONTINUED

Identify and analyze the unique needs of the area's population
- manpower
- facilities
- financing

Quantify goals for:
- community health promotion and protection
- prevention and detection
- diagnosis and treatment
- habilitation and rehabilitation
- maintenance
- support services
- enabling services

Address these service categories by settings.

Describe a healthful environment and health system. Address:
- availability
- accessibility
- cost
- acceptability
- continuity
- quality

Considers national and state guidelines and priorities in developing HSP.

Coordinate HSP development with SHFDA, SHCC.

Revise HSP to meet coordination of statewide needs as required by SHCC.

Explain relationship between HSP and AIP and ensure consistency between these two documents.

Prioritize AIP objectives that maximally improve health at least cost.

Seek to implement HSP and AUP.

Publish specific plans and projects for achieving the objectives established in the AIP.

PLAN IMPLEMENTATION/REVIEW ACTIVITIES AND HEALTH SYSTEM DEVELOPMENT

Develop criteria and procedures regarding evaluation of need for:
- modernization, construction, and conversion of medical facilities
- other plan facilitation activities
- new institutional health services
- appropriateness review
- certificate of need review
- Section 1122 review
- other plan implementation activities
- PUFF
Area Health Service Development Funds

Review the need for new institutional health services and make recommendations to the State Agency.

Review on a periodic basis (at least every five years) all institutional health services and make recommendations to the State Agency regarding the appropriateness of such services.

Annually recommend to the Secretary of DHHS and State Agency:
   A. Projects for modernization, construction, and conversion of medical facilities.
   B. Priorities among such projects.

Review and approve or disapprove or review and comment upon as appropriate each specified Proposed Use of Federal Funds within the Health Service Area.

Identify relationship between health status and health system goals.

Spell out long range recommended actions and resource requirements or implications in terms of manpower, facilities, equipment, and financial impact.

Develop procedures and policies for conflict of interest in Project Review.

Establish coordination between HSA and other agencies engaged in concurrent review of projects.

Establish policies, procedures, activities to ensure public involvement.

Provide consultation and technical assistance to prospective applicants in the preparation of proposals for review and other projects and programs which meet the objectives and priorities of the HSP and AIP.

Develop a monitoring and tracking system to assure that timely information is available on reviews.

Establish a post-review system to insure execution of projects as approved.

Maintain data on applications and/or consultations.

Develop Memoranda of Understanding with SHPDA, A-95 Clearinghouses.

HSA involvement in local, state, and national issues concerning health status of area residents and health system in area.

Make grants and enter into contracts with public and non-profit entities to assist them in planning and developing projects and programs which will achieve the objectives of the HSP.
DATA MANAGEMENT AND ANALYSIS

Identify, collect, and analyze data concerning:
- health status of area residents
- status of health care delivery system and use by residents
- effect of system on residents
- number, type, and location of area resources
- patterns of utilization of the area's health resources
- environmental and occupational exposure factors affecting immediate and long term health conditions

Develop policies, procedures, and systems for organizing, storing and retrieving information of the above types.

Coordinate data acquisition and analysis with the Cooperative Health Statistics System (CHSS), through an agreement with the CHSS, SHFDA, PSROs, other HSAs, A-95 Agencies, and other appropriate Federal, state and local agencies.

COORDINATION

Develop, adopt, and implement written agreements for the coordination of HSA activities with PSROs and A-95 Agencies in the area.

Coordinate in the areas of data, review, and input of documents, technical assistance, and implementation.

Coordinate activities with other Federal, state, and local entities.

PUBLIC INVOLVEMENT & EDUCATION

Develop and adopt procedures for public information and education regarding HSA functions and responsibilities.

Establish policies and procedures regarding public review and inspection of Agency documents, records, and data.

Ensure adequate notice of all meetings and hearings.

Develop an annual report concerning the activities of the Agency.

Develop and adopt policies and procedures for receiving public input on Agency functions and activities.

Develop, maintain, and make available for public inspection and copying, an index of the records and data of the Agency.

Develop strategies and programs for educating area residents about personal health care and services.

Provide each Indian Tribe which is located within its Health Service Area information respecting the availability of Federal Funds.
Mr. Rogers. Thank you very much. We appreciate your interest in being here.

Mr. Preyer.

Mr. Preyer. I thank you, too, and I think you have given us an eloquent statement of bottoms-up planning which will be very helpful.

Mr. Rogers. Thank you so much.
The next witness is another distinguished colleague of ours, the Honorable Gary Meyers from the State of Pennsylvania.

We welcome you to the committee and will be pleased to have your statement. It will be made a part of the record at this point and you may proceed.

STATEMENT OF HON. GARY A. MYERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Myers. Thank you, Mr. Chairman.

I appreciate the opportunity to appear here today and share briefly with the subcommittee some of my views on the health planning process. I will deviate from my prepared remarks and compliment you for honoring the commitment you have made on the floor of the House and to a number of us that you would provide the opportunity for input such as this.

We have had an active HSA in southwestern Pennsylvania and a great deal of public participation in a sometimes volatile health planning process. The views I will express are based on my observations of and participation in that process.

I realize the subcommittee has before it both subcommittee and administration bills proposing far-reaching changes in HSA structure and process, as well as recently altered HEW national health planning guidelines. While I may wish to comment on specific provisions of those bills or those guidelines in the future, I want to take this opportunity to share with you several overall principles which I believe should guide the subcommittee as it considers the important issues facing it.

The first principle that should guide health planning policy, in my opinion, is to keep decisionmaking as close as possible to the people. I know I am not telling the subcommittee something it has not heard before when I say that citizens in communities across the Nation are the individuals who build and who maintain community hospitals. Federal and State assistance has helped, but by and large it is local citizens who have raised the funds, issued the bonds and attracted the doctors. And, with all due regard to the need for regional health planning, it is these local citizens who should have the greatest say in decisions about providing health services.

This principle of local control is worth repeating as the subcommittee considers whether the locus of power in the planning process should be at the HSA, State or Federal level. I believe it should be underscored and it must be remembered as the subcommittee considers HSA composition issues.

Transferring power too far from the hands of local citizens or creating nonrepresentative boards can alienate citizens and com-
munities from the health planning process. Even now, many citizens in western Pennsylvania tend to view our HSA not as a local agency—as it is seen from Washington—but as a long arm of the Federal Government. And transferring decisionmaking power from localities can unfortunately destroy one of our Nation’s most vital health resources: local interest in and support of community health facilities. While this local interest and support is not conventionally listed among “health resources,” I submit that it far exceeds in importance very CAT scanner in the Nation. Once again, I urge the subcommittee to keep health planning as close as possible to the people.

A second principle that should guide Federal health planning decisions, in my estimation, is maximum flexibility both at the HSA level and at the sub-HSA level. There may be a time in the future when health planning techniques are sufficiently sophisticated and assured of bringing results so as to argue for rigid guidelines. Now, though, when health planning is still in its infancy, excessively rigid health system plans, certificate of need, or appropriateness review procedures serve only to alienate citizens and to achieve a nonproductive “leveling” effect.

I believe, at this state of health planning sophistication, that community medical facilities should be given considerable flexibility, and should be encouraged to comply with regional health plans rather than being forbidden to deviate from a prescribed system. Medical facilities not complying with HSA plans could be penalized through the medicare reimbursement system, for example, so that they lose that part of the reimbursement amount attributable to noncompliance facilities or services.

But there should be no absolute ban on providing services for which a local community is willing to pay a premium out of its own pockets. There should not be, in my estimation, federally supported groups telling local communities they absolutely cannot try harder and provide services above a mandated level.

Finally, Mr. Chairman, I would suggest as a third principle guiding the health planning process noninvolvement by HSA’s in social or moral issues peripheral to the health planning process. This is an area, Mr. Chairman, where I respectfully suggest the subcommittee may wish to provide guidance to HSA’s.

I do not believe, for example, that the issue of appropriateness of abortion should affect HSA health planning policies. Normally, I would not have even considered raising the abortion controversy in the context of health planning. However, the issue has already been raised in western Pennsylvania—and, I understand, in other areas of the Nation—since the HSA of southwestern Pennsylvania board passed a resolution supporting medicaid-funded abortions.

I am not interested in limiting the free speech of citizens serving on HSA boards. But the resolution to which I refer has caused considerable concern among pro-life groups in my district—justifiable concern, I believe—that the HSA board’s personal views on controversial social and moral issues will color the health planning process.

Regardless of whether one feels formal health planning will work or not, I believe there is a consensus that planning should be attempted on a rational, nonemotional basis. Interjecting controversial
topics like abortion rights into the debate can only further complicate the planning process. Once again, I urge the subcommittee to offer guidance to HEW to guard against permitting HSA involvement in social and moral issues.

Thank you again for the opportunity to appear here today, Mr. Chairman. I appreciate the subcommittee's consideration of my remarks.

I would also like to just briefly underscore what Congressman Stangeland pointed out. He had examples of local hospitals whose costs ran significantly below the national average. We had a community in our area where the hospital administrators could prove that the HSA was attempting to phase out a facility that was providing hospital care at a cost substantially below that at the facility to which the citizens would be diverted. It is not true that formal planning is correct in all cases. That is why I think flexibility should be made in all areas that it can be provided.

Mr. Rogers, Thank you. Your suggestions are helpful to the committee and will be carefully examined.

Mr. Preyer, I share your views about the noninvolvement of HSA's in social and moral issues. I think that will handicap the planning process. I wonder what kind of guidance we can give on that without interfering with their local autonomy and perhaps constitutional freedom of speech issue?

Mr. Myers, As I understand it, there are lobbying prohibitions currently in law that address the use of Federal funds. I think we should look at whatever way we can broaden that where the activities concern HSA's. I think the HSA board members have the right as individuals to take positions on social and moral issues. But as a body to pass a resolution which then may affect their decision to close one hospital which might have a service which perhaps might not be consistent with their moral values would, I think, cause a very difficult situation in the community and actually erode the confidence that health planning had been done on a basis absent of that particular bias.

I think the committee can in fact include strong language which would specifically point out the intent of Congress that we don't expect the bodies to embroil themselves in these social issues unless they are relevant to the mandate of planning that has been given to them and I think, within that mandate, there should be sufficient flexibility for them to express their personal opinions.

Mr. Preyer, Thank you, Mr. Chairman.

Mr. Rogers, Mr. Carter.

Mr. Carter, Thank you, Mr. Chairman.

I would like to congratulate the gentleman from Pennsylvania. You have a broad spectrum of citizens from every level of society in your HSA.

Mr. Myers, I guess it would depend on who you ask. If you ask the HSA membership, they probably think they have a broad spectrum. If you ask the individual citizens affected by the HSA decisions, there is currently a feeling that there is not a representative level of communities and, quite frankly, I think the process by
which individuals are elected to HSA boards is so well hidden that
the average participant in the community really does not know how
to prepare himself to become a member. I am not speaking of im-
mediately becoming a member, but to prepare himself in his plans
to become a member sometime in the future.

I think there is not, from my observation, a cross-section, suffi-
cient cross section represented in the agency.

Mr. CARTER. At the present time approximately 15 percent of the
membership throughout the country is composed of elected officials,
I believe. Do you think that is sufficient or should there be more, or
less? Should they be classified as providers or consumers?

Mr. MYERS. That is a difficult question because I think there could
be attempts by elected officials to utilize their membership on an
HSA board to enhance their other political aspirations. I think that
is a risk that should not be ignored.

I don’t think that we can accept the theory that simply because
somebody has been elected as a Member of Congress or a member
of the legislature of a State or as a city councilman that he is best
qualified to serve on a health planning board.

I am not sure that that is all that is necessary. I think whatever
the board’s makeup is, that certainly one of their responsibilities is
to consider the opinions of people who have been elected in the
communities. This can be done through the hearing process by per-
mitting an adequate interface between the two bodies.

Mr. CARTER. I want to thank the distinguished gentleman for his
excellent statement.

Mr. MYERS. Thank you, Dr. Carter. I appreciate your interest and
the subcommittee’s interest.

Mr. ROGERS. Thank you for your help.

Without objection, the Chair wishes to place in the record, as
though read, the statements of Congressman Stewart B. McKinney
of Connecticut and Hon. Baltasar Corrada, Resident Commissioner,
Puerto Rico.

[Statements of Congressman Stewart B. McKinney and Hon. Bal-
tasar Corrada, Resident Commissioner, Puerto Rico, follow:]

STATEMENT OF HON. STEWART B. MCKINNEY, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. MCKINNEY. Mr. Chairman and committee members: I value
this opportunity to offer the committee some first-hand insight into
the failure of HEW to properly administer the regional health sys-
tems program. I must also urge the committee to review and clarify
certain existing provisions under Public Law 93–641 and Public
Law 95–215, before further granting the regional HSA’s the power
to decertify certain medical facilities. I have personally witnessed,
Mr. Chairman, the controversy, anger and harm that can result
from misinterpretations of existing law. HEW has interpreted its
power to grant an extension of temporary designation for a Health
Systems Agency [HSA] one way, the public has interpreted its
right to a meaningful public comment period in another way. Hence,
before the national program for the establishment of regional health plans proceeds much further, this committee must clarify the Agency's power, the public's right to involvement and HEW's responsibility to respond to public concern.

I recently became involved in a matter regarding the proposed health systems plan [HSP] for Fairfield County, Conn. As a result of the overwhelming public concern in Fairfield County regarding the future possibility of decertifying certain hospital units, the lack of available information regarding the HSP's regional, economic impact, and the insufficient opportunity for full public comment, I solicited the assistance of both the HEW regional office in Boston and Secretary Joseph Califano. In both instances I requested that the fast-approaching deadline for submission of the Southwestern Connecticut Health Systems Agency's application for permanent designation be delayed for just 90 days in order to allow the public's overwhelming concern every opportunity to be fully expressed. It was not until I received the Secretary's official response to my request for extension, that I realized how harmful HEW's misinterpretation of existing law could be to the future of all H.S.A. programs in the country. It was also as a result of this response that I realized the importance of this committee's task in clarifying existing provisions to correct H.E.W.'s misinterpretation, and thereby mollify the public's legitimate concern that future plans will be arbitrarily forced upon them. Let me explain in more detail.

As a result of the controversy and inordinate public interest by Fairfield County resident's concerning the content of the proposed HSP. I sent Secretary Califano a letter outlining those concerns. [insert No. 1, see p. 913].

Unfortunately, Mr. Chairman, the Secretary's response not only lacked cognizance of the dilemma facing Fairfield County (as outlined in my letter), it also demonstrated an insensitivity to the public concern and an astonishing lack of knowledge of the language of the enabling legislation. Insert No. 2 [see p. 916] is the response bearing the secretary's signature.

Clearly the Secretary's response was inaccurate. The exact wording of Pub. L. 92-215 states:

The Secretary may upon application of a conditionally designated entity, extend for an additional period of not to exceed 12 months the period of such entity's conditional designation if the Secretary determines that (A) unusual circumstances exist. . . .

The conference report accompanying Pub. L. 95-215 (House Report 95-828), to which the Secretary refers in his letter, states:

Such circumstances which might cause the Secretary to make such a determination include but are by no means limited to (emphasis added) the following: --Agencies serving areas that in whole or in large part have had to devote a greater portion of their effort and resources in the first 2 years to organizational development, community involvement . . .

There is a clear contradiction between the Secretary's interpretation of the criterion needed to extend a programs' conditional designation and the conference reports interpretations of those same criteria. The Secretary's letter refers to a "rather specific list" of
unusual circumstances under which an extension would be granted. However, the conference report states that those unusual circumstances, including "community involvement", are by no means limited to that which the report lists. Furthermore, the Secretary's perfunctory reference to the need for public involvement does not do justice to the importance of public involvement in the ultimate success of a regional plan. Nor does his letter demonstrate a legitimate effort on the part of H.E.W. to become familiar with the situation in Fairfield County. Will this misinterpretation of the legislative intent of the law also prevail when citizens are faced with the more serious questions such as decertifying local medical facilities. H.E.W. has requested this committee to grant H.S.A.'s the power to decertify and I think the committee should take a long look at the quality of the administration of existing statutes before granting further powers under Pub. L. 93–641.

Lest any of the committee members incorrectly believe that the public concern in Fairfield County, to which I refer, is merely the uninformed protestations of some local politician, let me recount for the record the following facts.

The HSP for Fairfield County was first released to the public on Dec. 19, 1977 with the vote for final approval scheduled for February 7. At each of the four public hearings held to consider the plan—Jan. 25, 26, 27, and Feb. 2, 1978—well over 200 people attended. In fact, as mentioned in my letter to Mr. Califano, one meeting was closed because the number of attendees exceeded the legal capacity of the meeting hall. The groups in attendance represented diverse interests within the community, however, there was no question as to the commonality of their goal—an extension of time for meaningful public involvement in the plan. In addition to those attending the meetings, several groups in Fairfield County presented their criticism in well-documented written statements, which were submitted to the Southwestern Connecticut H.S.A. By way of example, a critique was submitted to the H.S.A. by the Stamford Area Commerce and Industry Association [see insert No. 3, p. 917].

Furthermore, Mr. Chairman, in response to the community's concerns, the governing board of the region's H.S.A. stated their willingness to participate in workshops in an effort to resolve any differences that might exist concerning the program's goals. Both the sponsors of the program and its critics were in contact with my office and the H.E.W. regional office in Boston. Clearly, a 90-day extension for public comment—which would have been obtained by a better understanding by H.E.W. of the criterion for that extension—would have insured a successful mandate for the regional health plan in Fairfield County. As it stands right now, Mr. Chairman, the public has been frustrated in their attempts to contribute and shape the program to their particular needs. They are concerned that H.E.W.'s apparent misinterpretation of the law as it pertains to extensions, may be an indication of future uncertainties that could result in the decertification of local medical facilities. They now view this well-intended program as one more example of arbitrary, government intervention in their lives.
It is indeed an unfortunate situation. Hopefully it is one that this committee can rectify. I would urge the committee to review the provisions dealing not only with the laws regarding extensions of conditional designation, but with any provisions which might allow the public more meaningful participation in the development of their regional health plan. Furthermore, Mr. Chairman, I would urge the committee to scrutinize the potential for misinterpretation in any additional provisions to the law, especially those concerning decertification. Any further mandate to Pub. L. 93–641 must include clear and unmistakable guidelines for the implementation of its goals.

[Testimony resumes on p. 926.]
[The attachments referred to follow:]
The Honorable Joseph A. Califano
Secretary
H.E.W.
200 Independence Avenue, S.W.
Room 615F
Washington, D.C. 20201

Dear Mr. Secretary:

I am writing you in behalf of hundreds of Fairfield County, Connecticut citizens who are interested, as I am, in implementing the most equitable and effective regional health systems plan possible. The concerned citizenry of our area is convinced that the only means by which to insure the implementation of an effective plan is through an extension of the program's deadline for the filing of an application for permanent designation. Your commitment to grant such an extension would allow a continuation of the overwhelming public interest in this program and would assure the public that its concern will not go unheeded.

Pursuant to Public Law 93-641 the Southwestern Connecticut Health Systems Agency must submit an application for permanent designation on February 13th, to the Department of H.E.W.'s Region I office in Boston. In recent weeks, upon completion of its Health Systems Plan, the agency has conducted three public hearings to illicit community comment on the proposal. At each of these meetings several hundred concerned community residents have been in attendance. In one instance, the attendance of over 500 people resulted in the cancellation of the meeting by the local fire marshall's office. Represented at each of these gatherings have been hospital administrators, consumer groups, industry and commerce executives, anti-abortion groups, and members of the medical community. The commonality of their concern belies the diversity of the groups interests and as such, provides a clear indication that further opportunity for community involvement is warranted. In fact, this relatively cohesive effort by so many varied interests constitutes both the problem and the potential solution for which I am requesting your assistance.

Since its publication, the proposed H.S.P. for the Southwestern Connecticut region has been subject to a great deal of criticism. Despite the strength of the complaints, however, I do not believe the program's critics wish the elimination of the regional agency or its function. Rather, these interested groups would like to continue their analysis of the program and work with the H.S.A. to implement the best plan for our region. Similarly, the governing board of our region's H.S.A. has expressed a willingness to work with the public in meeting that goal. They are,
however, understandably concerned that requesting an extension of the public review period, instead of filing an application for permanent designation by February 13th, may result in the rejection of the extension request and thus result in the termination of the agency and its two-year effort.

With the gracious cooperation of Mr. Robert Watson, the regional director of H.E.W.’s Boston office, I have become familiar with the process for reviewing applications for extension. It is my understanding that an extension is granted if "unusual circumstances" prevent the effective completion of the program within the specified time period. Given the uncertainty of the determinants in that review process, I can readily understand the governing boards reluctance to file for an extension. However, the unprecedented public interest in the development of an H.S.P. for this region, and the willingness of all-concerned to cooperate in workshops and other mechanisms for an effective program, has convinced me that an extension is well deserved and should be requested. As is the case with many federal programs the success or failure of the National Health Planning and Resource Development Program will depend on public interest and cooperation. In this particular instance, the success of the program may well be decided by granting the public 90 more days to actively participate.

Your direct intervention in this matter, Mr. Secretary, is needed to assure the governing board that the product of their two year effort will not be jeopardized by the rejection of their 90-day extension request. The board will meet on February 7th to vote either for an application for extension or permanent designation. I would like at that time to be able to give them your written assurance that their extension request will be granted without the loss of the agency.

Furthermore, Mr. Secretary, the public's overwhelming interest in this important health program should not go unrecognized or unrewarded. Anytime the federal government can get as many people actively interested in a federally initiated effort, it should jump at the opportunity to allow the public's involvement to continue unhindered. Granting a 90-day extension for further community involvement in this matter will assure a successful mandate for the program. To deny such a request will certainly result in a lack of community cooperation and will discourage the residents of Fairfield County, Connecticut from further involving themselves in other federal initiatives.
I respectfully urge you, Mr. Secretary, to intervene in behalf of Fairfield County and grant an unqualified 90-day extension. As previously stated, I would like to present to the board, prior to their February 7th meeting, your written commitment for extending the necessary deadlines. I very much appreciate your kind assistance in this matter, and I await your positive reply.

Sincerely,

Stewart B. McKinney, M.C.

SBM:hs
The Honorable Stewart B. McKinney  
House of Representatives  
Washington, D.C. 20515.

Dear Mr. McKinney:

Thank you for your letter of February 2 in which you urge me to assure the governing body of the Southwestern Connecticut Health Systems Agency that if they apply for an additional 90 days of conditional designation their request will be granted. I regret that I am unable to grant your request.

We were granted the authority to allow extensions of conditional designation in Public Law 95-215, but only in instances in which unusual circumstances prevail. The Conference Committee report that accompanied that Act provided a rather specific list of unusual circumstances. In our own recent policy guidance to the Health Systems Agencies we have stayed very close to the language of the Conference Committee report. Our Boston Regional Office staff report to us that the circumstances necessary to grant a waiver do not appear to be present in this situation, although it is impossible to make a definitive determination in the absence of a formal and detailed request by the Health Systems Agency—the only body empowered to seek a waiver.

I share your concern for the need for substantial public involvement in the process of establishing health systems plans. Our Boston Regional Office reassured me that while the public hearing of the 26th of January was cancelled, as you indicated, it was replaced by two additional public hearings which were held on January 28 and February 2.

I hope this information is helpful to you. If we can be of further assistance, please contact us.

Sincerely,

Joseph A. Califano Jr.
STATEMENT ON

REGIONAL HEALTH SYSTEMS PLAN

Submitted by
Stamford Area Commerce & Industry Association, Inc.
to Southwestern Connecticut Health Systems Agency
at Public Hearing
Thursday, January 25, 1978
Davenport Ridge School, Stamford, Conn.
Good evening. I am E. Gordon Goodlett, Director of Regional Development for the Stamford Area Commerce & Industry Association — SACIA.

SACIA represents over 350 businesses located in the eight-town region as identified by the Southwestern Regional Planning Agency (SWRPA). Its membership includes most of the major Fortune 500 companies which have located in this region over the past decade. It also includes virtually every major company in each of the principal business classifications represented in this region — manufacturing, finance, retail, service, and professional. However, more than 80% of its membership is what would generally be considered "small business" — i.e., 100 employees or less.

SACIA subscribes to the belief that there are a number of "quality of life" issues affecting the region that can best be addressed on a regional basis. They include transportation, housing, highway development and, of course, health systems management. We generally support truly comprehensive, rational, and sound regional planning as being essential to maintaining and enhancing the region's quality of life.

Business has a major stake in the proposed health system plan because it pays millions of dollars for employee health insurance plans and industrial health facilities which, conceivably, could be affected by the implementation plan for the next five years.

The purpose of the plan, as we understand it, is "the achievement of equal
access to quality health care at a reasonable cost." This is a laudable goal.
And, we have no quarrel with it. As much as the average citizen, business
also is concerned with the rising costs of health care services.
A recent survey of the SACIA membership indicated that 80% of those members
responding considered rising health care costs to be either "important" or
"very important."

This agency realizes, we are sure, that a large part of the health care costs
are paid by third party insurers, of which business is a significant part. The
costs of insurance premiums is often borne either fully, or in large part, by
businesses or their employees and, in many cases, their families. So, business
firms have a direct economic stake in higher health care costs through higher
premiums. There is a further impact resulting from time lost from
employees for health related reasons which is immeasurable. Nonetheless, it is
significant and of concern to all employers.

We acknowledge the work put into the development of this report by your Agency
through its task forces and sub-task forces. We have several major reservations
regarding both procedures and conclusions. However, it does not diminish our
respect for your efforts.

Nevertheless, our primary recommendation is that the Board of the Regional
Health System Agency not immediately adopt this report. In fact, we may eventu-
al urge that you not adopt it at all in its present form.

We make this recommendation for the following reasons:

First, the report -- its findings, conclusions and recommendations -- is
massive and highly complex and technical. The 470-page report was made available
only within the past month. It took 18 months to prepare the report. To expect the average citizen — or even individuals or organizations who have more than average resources to undertake evaluation of the report — to be able to evaluate and understand the report fully and intelligently is unfair and totally unrealistic.

We understand that the Agency is pushing final approval of the plan so it can realize its designation by the Health, Education and Welfare Department as the official regional Health Systems Agency. We believe that this rush to judgement or final approval is unwise over the long run. Inadequate, incomplete or erroneous understanding of the report and its recommendations for the sake of official Agency designation by HEW will be counterproductive to the Agency’s ability to achieve the plan’s objectives and goals.

Second, there is widespread misunderstanding regarding exactly what this report says or means. We certainly appreciate the fact that you are conducting a series of public hearings on the plan. However, we believe they are inadequate — again considering the lengthy preparation time for it and its complexity. The highly publicized disagreement over what this report says or does not say extends to the area professional medical community, citizen groups, and even we note to members of the Board of this agency who have been publically quoted disagreeing over interpretations of the plan’s recommendation. Meaningful and constructive understanding of the plan is difficult, if not impossible, if the various affected parties cannot agree on what the plan proposes or does not propose.

-3-
Over the past month or so, the reported disagreements, contradictions, and lack of adequate clarification has served to confuse, rather than enlighten the public on the intent and merits of the plan.

To compliment our initial recommendation, we further recommend that no final action be taken on the plan until a series of community workshops be held at which the plan would be thoroughly explained, analyzed and discussed. Recently, a year long study on Stamford's arts resources and needs was completed. It certainly was not as complex as your report. Nonetheless, it held a series of four community workshops to explain the report's recommendations and get public support for it -- which it got. We believe it essential that this be done with this report because of its very serious implications to the health care delivery system for the region and its people. As the May 1, 1977 Connecticut edition of the New York Times noted in an article on this issue: "At stake is the autonomy of the area's 17 institutions, the prerogatives and traditional independence of its 1,200 physicians, the interests of the area's 635,000 residents as represented by a handful of the agency, selected consumer advocates..."

We are also troubled by an apparent lack of input from significant elements of the region, which will be drastically affected by the plans you propose. It was unrealistic not to include them in the planning process.

For example, we have discerned very little reference to participation by the region's business community which, as we noted, has a great stake in the plan.
Had the major employers of the region been approached or cont.
business organizations like SACIA? To our knowledge, there is very... awareness by them of your agency and its grand plan for the region. No one approached us. Or, any of our members, as far as we have been able to
determine, to seek their reactions or to evaluate the action plans and goals as they were being developed. We do not accept the minimal representation on the
Task Forces by business as being adequate.

Your action plans -- particularly in the areas of Environmental Quality and OSHA-- could have profound effects on business. Yet, we see no evidence that... consideration was given to this impact in developing your plans. In fact, we perceive a disturbing lack of such analysis, or foresight. The overall priority, we have come to believe, was to complete the plan for approval and secure an agency designation -- at any cost.

We do not possess any great competency to discuss many of the medical aspects of your recommendation. Given the little amount of time we have had this report, the lack of community workshops, and the apparent disagreement, we do not feel capable of analyzing its medical contents.

There are two areas, at least, however, where we do believe we possess the requisite background and experience to comment. What we see in these areas does little to reassure us with regard to the whole report. I refer specifically to the sections on Environmental Quality and OSHA.
In the area of environmental quality, we find it difficult to argue with the basic goals. Your report correctly points out that there are problems in the region. It would be equally difficult to argue with either your facts or your conclusions. However, we find the report to be simplistic, unrealistic and, quite frankly, somewhat naive. It appears to be a condensation of other much more detailed reports. In our opinion, the long-range actions you propose will not meet the Plan's long-range objectives. The report makes some very casual references to solutions which are not all that simple to achieve.

For example, you promote the recommendations of the Connecticut Lung Association for reducing transportation-related hydrocarbons. Yet, the report almost totally ignores all of the problems being experienced by the Connecticut Department of Environmental Protection and the Federal EPA in promulgating a Connecticut Transportation Control Plan for reducing hydro-carbon emissions. You talk about seeking cooperation between health planning agencies and other planning agencies in New York, New Jersey and Connecticut as a way to reduce inter-state flux. This ignores the fact that Connecticut has actually been forced to consider suing New York to achieve cooperation. The report speaks in glowing terms of the Connecticut Resource Recovery Agency, yet, it ignores the fact that the construction completion deadline has recently been pushed into 1979 and final operation will be far beyond that -- perhaps even beyond the reaches of your five year plan.

We can agree with your long-range goals in Environmental Quality. However,
we are quite skeptical regarding the ability of your group to achieve them, especially through the so-called long-range plans outlined.

We also make it quite clear that our willingness to agree to the basic objectives does not automatically indicate our assent to some of the plans you suggest as solutions.

As far as OSHA is concerned, we are forced to conclude that your report really doesn't say anything nor does it make any realistic proposals. The report virtually ignores — or even negates — economics. You seem to have no perception of how much it costs to do something. Nor does it reflect an understanding of the needs of employers under this law — the same employers who provide the jobs, payrolls, and other economic benefits essential to the economic health of the region.

The only concrete action you propose relative to OSHA — 'other than trying to gain access to now-confidential documents and the development of training programs is to create in 1979 a task force to undertake studies. No indication is given as to who would be on this task force, its mission or its method of operation.

In the long range objectives for Ambulatory Care — on page 93 — of the Summary Plan, the report implies that "by 1982 a regional system of public transportation" would exist as a means of mass transit for the elderly and handicapped persons. A very noble thought. However, public and private agencies, inc: SWRPA and SACIA, have been working diligently yet frustratingly to bring about regional transportation systems. The Connecticut General Assembly and the State
Department of Transportation have tried — without much success to date. You just don’t wish a regional transportation system into place — as ideal as the objective is, which we happen to share.

Other sections of the report take on the appearance of being a "wish" book, with apparently little understanding of the complexities and difficulties in realizing these "wishes."

If the rest of this report produces as many concerns and questions in other minds as these sections cause in ours, we caution you against its acceptance. In fact, we urge a delay of 60 to 90 days to allow for a constructive dialogues on the report, from which better understanding and agreement could come.

Let me close by saying that, if this Board agrees with our conclusions, that it would be premature to accept this report at this time, we would stand ready to assist you in whatever way we can in communicating and explaining this plan to the broad community...not in a "public hearing" format with all its limitations, but in a true two-way dialogue that will result in a plan that works well for everyone.
STATEMENT OF HON. BALTASAR CORRADA, RESIDENT COMMISSIONER, PUERTO RICO

Mr. Corrada. Mr. Chairman and members of the subcommittee, it is a pleasure for me to be able to testify on H.R. 10460 and particularly in support of my bill H.R. 10418.

This bill is a simple one and would provide for the inclusion of Puerto Rico in section 1536(a) of the Public Health Service Act. The only thing this will do is make Puerto Rico a single area state for the purposes of the act.

Mr. Chairman, as I have previously written to you, the Government of Puerto Rico runs a very extensive public health service which provides health care to over 1.4 million persons or about half of our population. In order to do this, the Puerto Rico Department of Health has a very well staffed planning unit, which in many cases duplicates the work of the present HSA. In fact, the HSA's jurisdiction is identical to the Department of Health's planning unit, which is the local SHPDA. This produces a situation of overlapping responsibilities, duplication of efforts and wasted resources, time and funds, and both agencies are constantly interfering with each other's efforts to carry out their respective functions.

The SHPDA's resources were diminished by recent legislation and therefore, it is now short-handed in spite of having greater responsibilities. The HSA on the other hand, is over endowed with funds. The HSA does not recognize the SHPDA's role in health planning, as it (the HSA) feels it has the authority to carry out its plans regardless of the SHPDA's opinion.

As you can see, Mr. Chairman, this creates a serious problem for a government for which health planning has always been a question of public policy. Having an HSA that does not agree with the programs and philosophies of the Government can create serious disruptions in our health care delivery system.

Pub. L. 93–641—the Health Planning Act—was designed for the type of health care delivery system which predominates in the states and not for Puerto Rico, where as I have said before, the Government directly provides health care for about half of the population, particularly the medically indigent.

Our Government's considerably larger role in providing health services to the community demands that it have the authority to design and implement its own plans. As a matter of fact, the Puerto Rico Department of Health is quite capable of performing this task faster and at a much lower cost than the present HSA.

On the question of community participation, I would like to point out that a law recently enacted by the Puerto Rico legislature regarding health planning in Puerto Rico mandates and safeguards community participation in all aspects of the health planning process. The Government has every intention of promoting genuine and effective community participation in the process to the fullest extent possible.

Mr. Chairman, I would now like to briefly enumerate what we envision would be the benefits accruing to health planning in Puerto Rico if the provisions contained in my bill are enacted:
First. The Puerto Rico Health Department information system could be greatly improved.

Second. Health planning manpower could be better distributed throughout the island, since the Department has a highly developed regional organization.

Third. The entire planning process would be accelerated.

Fourth. The cost to both the Federal and State government would be greatly reduced, since having a single agency would mean cutting over-head and administrative expenses at least by half.

Fifth. The Health Department’s internal short-term planning and program needs would be better served. This would result in improved health services to the majority of the Puerto Rican people.

I believe, Mr. Chairman, that these are very sound reasons for my proposal and I hope that the subcommittee will agree with me that everyone would be better served at a reduced cost to the Federal Government.

I hope that you and the subcommittee members will support my bill.

Mr. Rogers. The next witness will be a panel of hospital representatives, Mr. John Alexander McMahon, who is president of American Hospital Association; Dr. Leo J. Gahrig, senior vice president of the American Hospital Association; and Michael D. Bromberg, executive director of the Federation of American Hospitals, accompanied by Mr. Robert J. Samsel, president of the Federation of American Hospitals.

We welcome you gentlemen. It might be helpful if you could highlight the major points you think we should hear. Your full statements will appear in the record.

STATEMENTS OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AND PAUL W. EARLE, VICE PRESIDENT; AND MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY ROBERT J. SAMSEL, PRESIDENT

Mr. McMahon. Thank you, Mr. Chairman.

Mr. Chairman, I am John Alexander McMahon, president of the American Hospital Association.

With me today are Leo J. Gehrig, M.D., senior vice president, and Paul W. Earle, vice president, of the Association.

We supported, as indicated in our statement [see p. —], the original planning law and the extension now before the committee.

We have some amendments to suggest to the planning law itself. They are found from pages 3 to 12 and then we have comments on your bill H.R. 10460. Those comments begin on page 12 and go to page 19.

We mention on page 3, Mr. Chairman, the voluntary cost containment effort, the fact that hospitals and physicians are concerned about the rate of increase in hospital costs and that it is exceeding the gross national product. We mention there the joint effort of the
AMA, the Federation of American Hospitals and, of course, our own activities. We will be keeping the committee in touch with those voluntary efforts as we have already and will be glad to respond to any questions if you have them.

Mr. Chairman, I would like to address myself specifically to four areas which we think ought to be touched on in the extension process and, of course, we could explore any others the committee would be interested in.

On page 4 we expressed our concern about the national guidelines for health planning because we believe that national guidelines should serve as a flexible guide to the development of local health plans and objectives. Mandatory Federal guidelines imposed uniformly on each HSA and in each State, with modifications only through a cumbersome exceptions process—as previously proposed by HEW in regulations—would prevent the development of viable health service plans adapted to local needs.

We have mentioned in our testimony the need to clarify the guidelines and the relationship between local and national authorities and in the attachment to our testimony we set forth a specific amendment which we think would clarify the confusion that exists and clarify the attempts, on occasion, of HEW to move farther than it should.

On page 5, Mr. Chairman, we have mentioned an amendment to expand the scope of the requirement for State certificate of need to encompass health capital expenditures without regard to ownership or location. We believe that the private offices of health practitioners should be subject to CON review to the extent those offices are proposing to obtain highly specialized equipment or develop facilities typically provided in an institutional setting.

We set forth in the testimony as an example the CAT scanner situation, and we mention specifically the amendment that we have proposed that would also apply to such activities as health maintenance organizations, surgical centers, extended care facilities, and home health care services.

One other thing, Mr. Chairman, we ought to make clear: our amendment takes a little different approach from yours because it is an amendment to section 1525. I think we are going in the same direction, but we are still at work studying this, and we will have further discussions to make and would like permission to pass those on later on as to how we can achieve this goal, whether in the further expansion of our suggested change in the definition or through your approach to broaden the definition of capital expenditures.

Mr. Rogers. We will be pleased to receive those suggestions.

Mr. McMahon. On page 7 we mention the amendment we have suggested on the composition of planning body governing boards. We think it appropriate to identify the need for hospital administrators to have a place on the governing boards of planning agencies. We made reference also to the need to redefine the term "indirect provider" to facilitate selection of interested, informed and effective consumer representatives.

In a survey we have undertaken, preliminary indicate half of the planning agencies don't have hospital management representa-
tives and, because of the importance of the hospital system, itself, in the area to the plans and in the modification of services over time, we think the planning process would be better served if they were there.

On page 9, Mr. Chairman, we have given attention to the problems of the confusion and duplication of construction standards and the multiplicity of agencies involved in their enforcement. These multiple codes produce added costs for institutions which must be passed on ultimately to producers and payers. We recommend a single set of codes and standards for the physical requirements of hospitals and other institutions and facilities. States and local governments would also be urged to adhere to these standards.

From pages 10 to 19 we have addressed some of the changes you set forth in H.R. 10460. I would like to address myself to only one of those. It begins on page 16 and it has to do specifically with the proposed new requirement that within four years States must have in effect a program under which services found to be inappropriate may not be provided in such States. We interpret this to mean there must be established a program of compulsory decertification and we oppose such a program. Compulsory decertification would cause serious community conflicts and raise issues of compliance with due process requirements, abrogation of contracts, and deprivation of private property without just compensation.

Closure, conversion, and merger of units, the steps that are effective means for dealing with excessive services, are likely to be successful if they are performed voluntarily, in conjunction with financial and other support from planning agencies, Government, and third-party payers.

We suggested—I am referring specifically to the language beginning at the top of page 17, that instead of compulsory decertification, consideration be given to substitute provisions to require the State to develop a program to facilitate the voluntary elimination of excessive services by helping to:

One: Satisfy the financial requirements related to the action;
Two: Provide orderly and timely access to alternate facilities and services for patients and physicians of the unit to be closed;
Three: Develop a plan for the best use of the unit to be closed;
Four: Secure other employment opportunities for employees of the unit; and
Five: Obtain the cooperation of the various parties affected by the change.

If steps such as these are taken, litigation, community opposition and political pressures to prevent the closure of services can be minimized. Therefore, we recommend this approach to obtaining cooperation in the elimination of excess capacity and duplication of facilities and services.

Thank you very much, Mr. Chairman, for the opportunity to present these thoughts.

We will at an appropriate time be pleased to answer any questions or elaborate on any of the points covered.

[Testimony resumes on p. 986.]

[Mr. McMahon’s prepared statement and attachment follow:]
Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me today are Leo J. Gehrig, M.D., Senior Vice President, and Paul W. Earle, Vice President, of the Association. Our Association represents some 6,500 member institutions, including most of the nation's hospitals, as well as extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 24,000 personal members. We appreciate this opportunity to present the views of the Association on Public Law 93-641, the National Health Planning and Resources Development Act of 1974, and your bill H.R. 10460, the Health Planning and Resources Development Amendments of 1978, which would amend and extend this law.

Background

Our Association has supported the enactment and implementation of P.L. 93-641, and we endorse this extension. We are committed to the overall goal of this legislation—to improve access to quality health care services, while containing costs, through the development of effective planning processes at the local level. As a result of our continued interest and involvement in the implementation of P.L. 93-641, we have identified, and strongly recommend to this committee, some specific amendments.
to this Act. These amendments deal with areas of concern to the hospital field which we believe warrant modifications that will improve the basic statute.

We believe that health planning must be based on health needs identified by Health Systems Agencies (HSAs) and others through a number of planning techniques. The methodology of planning must take into account a variety of factors which apply to the planning area, including the incidence and prevalence of disease, the socio-demographic characteristics of the population, the present status of the health care delivery system, and the attitudes of the community regarding the delivery of health care services.

The key objective of such planning is the development of a health care delivery system that meets the health needs of all the people in the area and is adaptive to changes in these needs. Because of its important role in the provision of health care services, the hospital has a special responsibility to plan effectively; indeed, it is a major focus of attention in the planning effort. Therefore, it is particularly important that hospitals be represented and participate in the planning process at all levels—local, state, and national.

We strongly support and encourage the development by HEW of sound health planning tools, guidelines, standards, and methodologies to assist the planning agencies at the local and state levels, without imposing rigid formulas from the top. The health planning process can work most effectively through a "bottom-up" approach. Such an approach must provide for a clear-cut distinction between health planning at the local level; health planning and regulation on the state level; and the role of the federal government in providing guidelines and support at the national level.

An important problem in the implementation of this Act has been the difficulty encountered by planning agencies in establishing viable and up-to-date health care plans for the areas served. Only 9 of the 206 HSAs have been fully designated,
indicating that they have approved Health System Plans (HSPs). In addition, while more than 70 percent of all the states have certificate-of-need (CON) laws, only one state has had its CON program approved under the P.L.93-641 implementing regulations. The exigencies of developing regulations, recruiting staff, and securing adequate funds have combined to impede the development of the health plans that are essential to such state-level regulatory processes as CON for the control of capital expenditures.

Health planning, CON, and quality assurance programs are some of the cost containment efforts which have been, and are, underway. The voluntary effort to control costs currently being undertaken by this Association, together with the American Medical Association and the Federation of American Hospitals, will complement these statutory programs. This voluntary effort is headed by a National Steering Committee on Voluntary Cost Containment, which includes representatives of hospitals, physicians, insurers, consumers, industry, and management. State-level committees, under the leadership of state hospital associations and state medical societies, with similar representation, are being established to adapt the national objectives of this steering committee to local situations. The voluntary program is seeking to address inflation in health care costs which have been impacted by such factors as rises in the costs of goods and services hospitals must purchase, improvements in the services they offer, and increases in the intensity and demand for the care they provide. We would be pleased to supply for the record additional materials concerning this program, if the committee desires.

*Summary of AHA Recommended Amendments to P.L.93-641*

As we have stated previously, the issue of health planning has been a top priority of the Association. The following recommended amendments to the law address certain problems that we have observed in the implementation of this program. We are pleased
to note that some of these problems are also addressed in the changes provided for in your bill, H.R.10460. Mr. Chairman, we urge you and the committee to favorably consider our recommendations in revising the law. Detailed rationales and legislative language for each of our suggested amendments are appended.

National Guidelines for Health Planning

As a first step in ensuring a sound and effective planning process, at the local and state levels, we strongly believe that the National Guidelines for Health Planning should serve as a flexible guide to the development of local health plans and objectives. Mandatory federal guidelines, imposed uniformly by each HSA and in each state, with modifications only through a cumbersome exceptions process (as previously proposed by HEW in regulations), would prevent the development of viable health service plans adapted to local needs. They would also make the federal government the preeminent planner and others mere agents carrying out the will of those at the top.

We believe that whenever standards, numbers, and formulas are developed in HEW guidelines, they should be considered in the light of and adapted to local situations. To clarify the relationships between local and national authorities, as intended in the original law, the Association proposes an amendment to Section 1513(b) which will make it clear that the National Guidelines be taken into consideration by HSAs, in the formulation of health plans, rather than be imposed as inflexible, mandatory rules, to be rigidly followed at the local level.

Functions and Procedures of Planning Agencies

We firmly believe that the scope of CON should be broadened and that the functions and procedures of planning agencies should be more adequately defined, to increase the effectiveness and equity of the health planning program. Following are several amendments which are designed to achieve these goals.
A. The first of these amendments would expand the scope of the requirement for state CON laws to encompass health capital expenditures without regard to ownership or location. We believe that the private offices of health practitioners should be subject to CON review to the extent that those offices are proposing to obtain highly specialized equipment or develop facilities that are typically provided in an institutional setting. It is our belief that the scope of the CON process should not be limited to a portion of the health system. For example, the requirement for CON must prevent not only the undue proliferation of hospital-based CAT scanners, but also the proliferation of such scanners in other settings. In addition to the application of CON to the physician's office as we have described, CON coverage should also apply to such activities as health maintenance organizations, ambulatory surgical centers, extended-care facilities, and home health services. Health facilities and services can now be established in a variety of settings, without following local and state health plans and without obtaining CON approval while in other settings these same facilities and services are subject to rigorous controls.

B. We also are recommending a group of related amendments that are designed to clarify the advisory roles of HSAs and Statewide Health Coordinating Councils (SHCCs) with regard to review of applications for various types of federal funds. Current law suggests that the federal government has delegated to HSAs, and, in some instances, to SHCCs, the decision-making authority over applications for federal health grants to local entities or to states. We do not believe that this is, or should be, the practice.

The distinction which we propose between advisory and decision-making roles would keep local planning agencies in the business of planning and out of the realm of making grant awards. The final decision regarding federal project grants rests with the responsible federal agency, taking into account the recommendations of local planning units.
In a related issue, we believe that the provisions of P.L.93-641 which would provide area health services development funds to HSAs should be changed. This authority dilutes the focus of HSA planning activity by extending the functions of the agency to grant making and grant managing. While we agree that these development funds should be available to meet certain identified local needs, we believe that grant making and grant managing in this program should be the responsibility of the state agency, rather than of the HSA. Statewide health services development funds should be earmarked for projects which have been identified and recommended by HSAs.

C. Additional amendments we propose would consolidate all of the P.L.93-641 requirements for review procedures into Section 1532, where most of them now appear. These amendments would (1) require that proposed projects shall be deemed to be approved unless they are rejected by written opinion within the 90-day statutory review period; (2) provide for a public forum to be held by the HSA, at the local level, at which all interested persons may appear and present statements or evidence on the application being considered or the review being conducted; and (3) permit a formal hearing to be requested by either the HSA or the applicant, prior to the decision of the state agency, on a CON application or appropriateness review.

D. Our Association believes that the planning process would be strengthened if HSAs were permitted initially to phase in their functions in an orderly manner, according to their capabilities and resources. We are proposing an amendment to Section 1513(b) to accomplish this purpose. We believe that our amendment would improve the credibility and effectiveness of HSAs by requiring them to perform functions within—rather than beyond—their capabilities and resources.
Composition of Planning Body Governing Boards

The underlying philosophy of P.L.93-641 is that health care planning is to be developed through an effective coalition, at the local level, of consumer and provider representatives. Confusion and ambiguity in the language of the statute regarding representational requirements on HSA governing boards have, in some instances, impeded the achievement of this important goal of the Act. Accordingly, we have developed amendments to Sections 1503(b), 1512(b), and 1524(b) that would assure direct representation of hospital administrators on the governing boards of planning agencies, and that would redefine the term "indirect provider" to facilitate selection of interested, informed, and effective consumer representatives.

A. Current law does not require that hospitals be represented by persons directly involved in hospital administration. Therefore, institutions may be represented by individuals who are not in the best position to reflect the views of hospital management. We propose amendments to ensure that representatives of hospital administration be included at all levels of the planning process, and be eligible for membership on an HSA board if either their residence or place of principal employment is within the health service area.

B. Although the potential for economic conflicts of interest is a valid concern, the definition of "indirect provider" in Section 1531 is overly broad. We believe that the definition misclassifies as providers persons who have only tangential, incidental, or indirect ties to the health system. The definition also includes others, such as insurers, whose roles and responsibilities are those of purchasers. Such persons should be classified as consumer representatives.

Accordingly, the Association recommends amendments that would revise the definition of "indirect provider" to exclude (1) members of the immediate family of an indirect provider, (2) any individual who receives less than one quarter
of his or her gross income from a health care interest, a direct provider, or certain other health activities, and (3) insurers who do not provide health services to the public, either directly or through affiliates or subsidiaries.

Appropriateness Review

We suggest that the appropriateness review sections in P.L.93-641 are unnecessary and recommend their deletion from the law. A definition of this function has not been developed, and standards and guidelines have not been proposed to assist HSAs and state agencies with implementation—reflections of the difficulties this requirement poses.

A major problem is created by the fact that the law now requires HSAs and state agencies to review, on a periodic basis, each individual service and facility within the area or the state to determine its appropriateness. The magnitude of this burden can be appreciated when one considers that there are over 7,000 hospitals, many of which provide a broad range of services; more than 22,000 nursing homes; and many other institutional providers—all of which require appropriateness review. We believe that such a requirement adds an impossible burden to planning agencies, which have more urgent tasks to accomplish.

We believe that the overall assessment of the appropriateness of facilities and services is a part of the preparation of an HSP. On the other hand, we do not believe that an individual review for appropriateness of the myriad of services offered in an area is an effective use of planning resources. Therefore, we recommend the deletion of appropriateness review from the functions of HSAs, as detailed in Section 1513(g), and State Health Planning and Development Agencies (SHPDAs), as stated in Sections 1523(a)(b) and 1523(b)(3).
Federal Hospital Construction Standards

Health care facilities are frequently subject to the construction standards of a multiplicity of agencies. Federal agencies, such as HEW, the Department of Labor, and the Department of Housing and Urban Development, often require compliance with construction standards as a condition for participation in their programs or for financial assistance. State and local agencies also impose standards through various certification of licensure laws and building, fire, and sanitation codes.

Further complicating the situation is the fact that new codes are constantly under development and old ones are subject to frequent revisions. Different authorities often enforce different revisions. Multiple codes produce added costs for institutions, which ultimately must be passed on to their patients and to third-party payers.

The Association believes that the federal government should take the lead in resolving this situation by developing a single set of codes and standards for the physical requirements of hospitals and other institutional health facilities which would apply to all federal programs and to which state and local governments would be encouraged to adhere.

In regard to state and local authorities, there may be, in some instances, a demonstrated need for different emphases in different parts of the country because of geographical or environmental distinctions. These distinctions can generally be accommodated by permitting state and local authorities to impose additional, but not conflicting, requirements to account for hazards from earthquakes, hurricanes, floods, blizzards, and the like.
Provision of 'Free Care'

Under the original Hill-Burton Act (Title VI of the Public Health Service Act) implementing regulations, each applicant for a hospital construction grant was required to assure that a reasonable volume of hospital services, subject to financial feasibility, would be made available by the hospital to persons unable to pay—a provision still in effect. The statute also included a provision that, if any hospital receiving assistance under the program would cease operation or be converted from use as a nonprofit facility within 20 years from the completion of construction, the United States would be entitled to recover a portion of the assistance provided. No repayment was required beyond the 20-year period.

Some 25 years after the original law was enacted, additional regulations were promulgated to quantify the volume of free services which those receiving Hill-Burton assistance would be required to provide. Under these regulations, as amended and now in effect, hospitals in receipt of Hill-Burton assistance are required to account, during a 20-year period, for the free care they provide. The total cost of free care that can be required within the 20-year period may be twice the amount of the original Hill-Burton assistance, or even more.

Recognizing that hospitals not only have provided, but also will continue to provide, free care to persons unable to pay, we oppose imposition of a burdensome reporting and verification system in perpetuity, as included in the proposed new Subparagraph (J) of Paragraph 1621(b)(1) of your bill. Instead, we recommend that such required reporting continue to be limited to the 20-year recovery period, and ask that the committee adopt our amendment which provides for this limitation.

Grants and Contributions to HSAs

Health planning agencies must be assured adequate funds during their critical stage of development. Therefore, we propose amendments to Sections 1512(b) and 1516(b) which would permit a broader base of private and public contributions to HSAs.
Uniform Cost Accounting and Reporting

The AHA supports uniform reporting of costs, rates, and services, but does not favor extension of that principle to the requirement of uniform accounting for all health care institutions. We recommend that the portion of Section 1533(d) which requires the development of uniform cost-accounting and -reporting systems be amended to make it consistent with the provisions for uniform reporting and reconciliation systems that were enacted last year in Section 19(a) of the Medicare and Medicaid Anti-Fraud and -Abuse Amendments, P.L.95-142. In addition, we recommend amendment of Section 1502(9) to be consistent with these recommended changes in Section 1533(d).

Legal Structure of HSAs

P.L.93-641 currently permits not-for-profit corporations, public regional planning bodies, or units of local government to be designated as HSAs. We believe there would be a conflict of interest if an agency of local government, which was also a major purchaser or provider of health services, were designated as an HSA. We propose an amendment to clarify that governmental agencies that are substantial purchasers or substantial providers of health care services should not be designated as HSAs. This amendment is proposed to prevent the possibility that decisions about health planning and resource allocation will be made by agencies with the responsibility of purchasing or providing health care services.

Coordination of Planning

The Association supports amendments which would encourage coordination between the internal planning efforts of health care institutions and planning by HSAs. Experience has demonstrated that effective health planning requires a combination of individual efforts and extensive cooperation between public planning agencies and institutions within the planning area. The health planning statute should
recognize that planning agencies and health care institutions each have responsibility in the total planning effort.

The HSA should help determine what services and facilities are necessary to achieve the most effective and efficient levels and scope of health care for the health service area, within local resource limitations. On the other hand, the HSA's responsibility should stop short of determining how such services should be administered and how such facilities should be managed. These functions are the responsibility of hospital management. Hospital administrators, trustees, and medical staffs are best able to evaluate the needs and capabilities of their institutions and to assess actions for improving them. Regulations enforced by the HSA should provide freedom for the exercise of management prerogatives to attain planning objectives. To this end, the Association recommends an amendment to Section 1513(d) and adds a new Subsection (i) to Section 1513.

AHA Views on H.R.10460

Mr. Chairman, to assist the committee in its deliberations, we would like to share with you our reaction to some of the provisions of H.R.10460, the Health Planning and Resources Development Amendments of 1978. We wish to indicate our support for many of the changes in P.L.93-641 which you have incorporated in the bill and to recommend either modification or deletion of other provisions in the legislation.

Section 208—Local Financial Support of HSAs

AHA supports Section 208, which allows HSAs to accept financial support from insurers and permits such support to be counted for purposes of federal matching funds. The success of health planning at the HSA level depends not only on the quality of staff but also on the resources available. We feel that health insurers can provide
HSAs with important financial support without introducing significant potential for conflict of interest in the planning process. In this regard, we support at least this proposed expansion of non-federal funding sources, and we have detailed our recommendation for further expansion in an attached amendment.

Section 209—Membership Requirements

In general, we favor the changes made in Section 209; in addition, we propose that Paragraph (2) of Section 209(d) be modified so that the definition of "indirect provider" excludes the spouse as well as other members of the immediate family of an "indirect provider."

We also note that one of our proposed amendments would change the requirements for composition of HSA governing boards to insure that the provider members include a direct representative of hospital administration. We are pleased that you have provided in Paragraph (2) of Section 209(d) that an individual can qualify for HSA board membership on the basis of either place of residence or place of employment.

Section 213—Support and Reimbursement for Members of Governing Bodies;
Section 215—Staff Expertise

AHA supports Sections 213 and 215, which require that HSAs have a program of training and education for board and executive committee members, and that HSA staff expertise include finance, economics, and public health issues. Rational planning decisions can be made only by informed, knowledgeable individuals who have the benefit of adequate staff work. The addition of these requirements will certainly strengthen the planning process.

We suggest, however, that Section 215 be modified to include a requirement that HSA staff expertise encompass hospital administration, inasmuch as a full understanding of the complexities of operating and financing a hospital is essential for the proper analysis of institutional health care.
Section 216—Health Plan Requirements

We note that Subsection 216(a) of the bill would require that a SHCC establish a "uniform format" for HSPs, and that Paragraph (2) of Section 216(c) would require HSPs to be responsive to statewide health needs that are identified by the SHFDA.

In our view, the term "uniform format" needs to be more precisely defined. If the subcommittee's intention is that the SHCC shall prescribe the organization and presentation of HSPs to achieve a uniformity to facilitate review, then we do not object. However, the term as currently drafted could result in a SHCC's attempting to impose a particular methodology on HSAs for the actual development of the HSP. We would oppose this authority for SHCCs, and we suggest that this provision be redrafted to clarify its intent.

With regard to Paragraph (2) of Section 216(c), we suggest that such an amendment would confuse the existing statutory relationship between HSAs, SHPDAs, and SHCCs, in that present law provides that SHCCs review and require revision of HSPs with a view toward coordinating local health goals and statewide needs. The addition of a provision which permits a direct reconciliation between the SHFDA and the HSA would confuse the process and duplicate the function of the SHCC. We recommend either deletion of this provision, or the substitution of "SHCC" for "SHFDA," to retain current procedures.

Section 218—CON Programs

In our view, an important amendment in H.R.10460 is contained in Paragraphs (1) and (3) of Section 218(b), which expand federal requirements for state CON programs, to mandate coverage of major medical equipment, certain defined capital expenditures by health care facilities, and home health services. Our Association strongly supports these provisions, because we believe that uniform application of state CON programs to services and facilities is essential to an effective planning process.
Specifically, we feel that CON must cover major medical equipment regardless of ownership or setting, as well as health services that would otherwise be covered by the review process if proposed by institutional providers. This, of course, would not extend coverage to expenditures involving private practitioners in the development or maintenance of a usual practice.

Failure to expand CON coverage could only encourage the proliferation of major medical equipment, facilities, and services in a manner wholly inconsistent with the purpose of the Act. Progress toward the goals established in local and state health plans could be seriously undermined.

Further, we support the proposed new Paragraph (5) of Section 1527(a), which would require that CON programs have an identified appeals mechanism for applicants to seek review of adverse CON decisions, with such mechanism established consistent with individual state administrative practices and procedures.

We also suggest redrafting of Paragraph (4) of Section 218(b), which would amend Section 1532(b)(2) of the Act to allow up to one year for action on CON applications after receipt by an HSA or a SHFDA. If the purpose of this amendment is to allow batch processing of applications, we must point out that the provision, as currently drafted, would make a one-year general delay on a final recommendation or decision permissible, even when batch processing is not an issue.

We oppose permitting such a delay between receipt and action on CON applications, because this would impede efforts to meet the needs of the health care delivery system, and would jeopardize the arrangements made by applicants for financing, purchase, and construction.

Finally, in this section, we suggest that the proposed Paragraph 6 of Section 1527(a), which requires that state agency decisions on CON applications be consistent with
the State Health Plan (SHP), is too restrictive, because one cannot reasonably
expect that all justifiable needs will be anticipated in such a plan. We recommend
that more flexibility be allowed, so that a state agency can grant CONs in cases
in which there is clear need, though not specifically anticipated and included
in the SHP.

Section 219—Appropriateness Review

Section 219 provides for two changes in the review of the appropriateness of services.
The first of these changes would modify the requirement of present law that all
institutional services be reviewed, to stipulate that reviews be made of only
those institutional or home health services designated by the Secretary. As
we testified earlier, we propose instead that the requirement for appropriateness
reviews be deleted in its entirety.

The second proposed change would add a requirement that within four years a state
must have in effect a program under which services found to be inappropriate
"may not be provided" in such state. We interpret this to mean there must
be established a program of compulsory decertification. We strongly oppose
such a program.

Compulsory decertification will cause serious community conflicts and raise issues
of compliance with due process requirements, abrogation of contracts, and deprivation
of private property without just compensation.

Closure, conversion, and merger of units, the steps that are effective means for
dealing with excessive services, are likely to be successful if they are performed
voluntarily, in conjunction with financial and other support from planning agencies,
government, and third-party payers.
Provision for financial and other incentives would be one element in establishing an environment in which voluntary elimination of excess services could be encouraged. While opposing Section 219, we suggest consideration of substitute provisions to require the state to develop a program to facilitate the voluntary elimination of excessive services by helping to:

1. satisfy the financial requirements related to the action;
2. provide orderly and timely access to alternate facilities and services for patients and physicians of the unit to be closed;
3. develop a plan for the best use of the unit to be closed;
4. secure other employment opportunities for employees of the unit; and
5. obtain the cooperation of the various parties affected by the change.

If steps such as these are taken, litigation, community opposition, and political pressures to prevent the closure of services can be minimized. Therefore, we recommend this approach to obtaining cooperation in the elimination of excess capacity and duplication of facilities and services.

Section 220—Review and Approval of Proposed Uses of Federal Funds

This provision amends in several respects the provisions of current law which relate to HSA and SHCC review and approval of federal grants and contracts. While we do not object to the intent of these amendments, we do recommend that this review function encompass "review and comment"—as we have proposed in our amendments—rather than "review and approval or disapproval."

Section 224—Authorizations

We note that there is a provision within Subsection 224 which increases the authorization for the area health services development fund, provided in Section 1640(d) of the Act. We support the level of the authorization, but urge the
adoption of our proposed amendment to transfer this activity from the HSA to
the state agency. We believe that the authorization levels provided here would also
be suitable for the state-level activity.

In this same area, we also would like to indicate support for the increases in the
minimum grants to HSAs, for the change in the formula for calculating HSA planning
grants proposed in Section 206 of the bill, and for the increases in overall
authorizations for HSAs and state agencies contained in Section 224. An effective
health planning process requires consistent and adequate financial support,
particularly in its critical developmental phase.

Section 301—Health Resources Development

Section 301 of Title III of H.R.10460 would delete the present grant program for the
modernization and construction of public and private not-for-profit health care
facilities contained in Part B of Title XVI of the Act, and would extend the
loan and loan guarantee program for such facilities under Part C. Further, the
bill would amend Section 1625 to increase the authorization level for construction
or modernization project grants to public hospitals to eliminate or prevent safety
hazards or to avoid noncompliance with state or voluntary licensure or accreditation
standards.

The AHA supports this needed program of assistance to public hospitals, but recommends
that the authority be expanded to also include justified projects for private,
not-for-profit facilities. Such a grant program would certainly be limited to
assisting projects where both need and the financial condition of institutions
make such support imperative. There are private not-for-profit facilities providing
essential access to health care services in both urban and rural poverty areas which
are incapable of mobilizing the necessary capital for the purposes identified in
section 1625, and for whom loan qualification would not be feasible because of
their precarious financial condition. In these instances the availability of some government funds is crucial. Therefore, we recommend the inclusion of not-for-profit facilities in this targeted grant program.

The bill also would amend Section 1625 to authorize a new project grant program for the construction of outpatient medical facilities or the conversion of facilities to this use for medically underserved populations. We support this amendment and we again urge both government and private health insurers to improve their coverage for services provided in this setting.

We do oppose the proposed new Subparagraph (J) of Paragraph 1621(b)(1) in your bill. This subparagraph, in part, requires the accountability for charity care services to extend in perpetuity for any facility receiving assistance under this program. In the discussion of our amendments earlier, we included our reasons for this position and we urge the committee to delete this requirement.

Conclusion

Mr. Chairman, the American Hospital Association continues to support development of sound health planning through the successful implementation of the National Health Planning and Resources Development Act of 1974. You can be sure that we stand ready to assist you and the members of the committee in any way we can to modify the Act to assure such development.

We will be pleased to respond to any questions you or other members of the committee may have.
The following outlines the policy positions regarding the American Hospital Association amendments to the National Health Planning and Resources Development Act of 1974. These amendments reflect hospital concerns for the implementation of this Act and for achieving an orderly planning process for the health care industry.

Each amendment issue is described in the following way: First, there is the policy position of the American Hospital Association approved by the Board. Second, the rationale supporting each amendment is shown. Third, the new words to be included in the legislative language have been underlined and the words to be deleted have been crossed out.
1. Clarification of the Relationship between the National Goals and Standards and the Local Planning Activities
Section 1513(b)(2)

a. Policy Position. American Hospital Association supports amendments to P.L. 93-641 which will make it clear that planning activities are to be conducted primarily at the local level, with a minimum of interference from statewide and federal agencies.

b. Rationale. In the preamble to proposed National Health Planning Guidelines, issued September 25, 1977, the Department of Health, Education and Welfare asserted its view that the national guidelines specified by Section 1501 of P.L. 93-641 were required to be included as minimum goals and standards in local health systems plans (HSPs) annual implementation plans (AIPs) and statewide health plans as well as in state medical facilities plans. This is an effort to impose "top down" planning instead of the "bottom up" planning which we believe was clearly intended by Congress in passing the statute.

While supporting the issuance of national guidelines as targets for the nation as a whole to achieve, AHA opposes the Department's attempted extension of its statutory authority. Mandatory guidelines are a contradiction in terms which would hamstring health systems agencies in their planning efforts and would give preeminence to the role of federal planning. Such a result is contrary to the express requirement of the statute that health planning must be "responsive to the unique needs and resources of the [health service] area."

(Section 1513(b)(2)(B).

To reinforce the balance between local and national authority which was struck by the original enactment, American Hospital Association proposes amendments to the law which will make it clear that although the national guidelines must be taken into consideration by health systems agencies, they are not to be considered as inflexible, mandatory parts of the local planning process.

c. Legislative Language. American Hospital Association submits the following language as an amendment to the National Health Planning and Resources Development Act of 1974, to accomplish the foregoing objectives:

"Functions of Health Systems Agencies

SECTION 1513(b)(2)

*(C) which 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.*

"*(S) The agency shall submit to the State Agency a detailed statement of the reasons for any inconsistency between its HSP or AIP and the national guidelines and priorities established under this Act.**
2. Definition of Institutional Health Services
Section 1531(5)

a. Policy Position. The American Hospital Association supports an amendment to require a review of specialized equipment and facilities regardless of setting or ownership.

b. Rationale. The purpose of this amendment is to clarify that the facilities and programs subject to review by Health Systems Agencies and approved by state certificate of need agencies should include all facilities and programs irrespective of ownership, exempting only the private offices of health practitioners to the extent that those offices do not include highly specialized equipment. We believe the principle regulatory tool assigned to the state government by P.L. 95-641 is certification of need (GNX). It is the process whereby the state grants permission to health care providers to change their scope of services or to make significant capital improvements. No institution or service should be excluded from the certificate of need process because of its ownership, including a facility or service operated by a governmental or quasi-governmental agency or unit.

The pressures continue to arise wholly or partially to exempt this or that category of provider from the controls of certificate of need. The major response to these pleas for exemption is to ask where it would end. Is it really intended that certificate of need should cover only non-profit general inpatient care facilities? Is it realistic to expect certificate of need to hold down excessive health care costs if it can regulate only a portion of the development of the system's capacity? If a certificate of need program can, for example, try to prevent the proliferation of hospital based CAT scanners only to see a proliferation of CAT scanners by physician owners, has the law's intent really been served? If health maintenance organizations or ambulatory surgery centers or extended care facilities can be established without reference to state regulations and irrespective of how poorly planned they might be, what purpose is there in holding other kinds of facilities making similar proposals to more rigorous standards? If one goal of P.L. 93-641 is to contain health care costs by controlling the development of new or altered services and facilities, then we believe that no related institution or service should be excluded from the planning and review process regardless of ownership.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

DEFINITION OF INSTITUTIONAL HEALTH SERVICES
Section 1531(5)

"(5) The term 'institutional health services' means the health services provided by or through health care facilities and health maintenance organizations irrespective of ownership (as such facilities and organizations are defined in regulations prescribed under section 1122 of the Social Security Act or in regulations prescribed under section 1523 of this Act), including, but not limited to hospitals; nursing homes; extended care institutions; ambulatory care facilities; clinical referral laboratories;
radiation therapy units; specialized radiographic units; mental health, alcoholism, and drug abuse facilities; rehabilitation centers; and other facilities for the provision of specialized health services and includes the entities through which such services are provided, but the term shall not include facilities established solely for the professional activities of physicians, dentists, or other health care practitioners practicing singly or in organized groups, except where such services are provided by or through highly technical or specialized facilities or equipment."
3. Review Functions of Health Systems Agencies
   Section 1513(e)(1) and (2)

a. Policy Position. The American Hospital Association supports an amendment to
   ensure that Health Systems Agencies review and make recommendations and, as
   such, are advisory rather than decision-making bodies.

b. Rationale. The purpose of this amendment is to clarify that the responsibilities
   of the Health Systems Agency (HSA) should be advisory only, and that its function
   should be to review and make recommendations to the HEW Secretary or to the
   State Agency, as the case may be.

   We believe that the Health Systems Agency should neither commit funds nor
   deny them. We believe that this change should be made because ambiguous
   wording in the current law suggests that the federal government has delegated
   to Health Systems Agencies final decision-making authority over federal health
   grants in the local area. Of course, a local Health Systems Agency's approval
   or disapproval of an application to a federal agency for a grant does not
   constitute final federal action. The Secretary of HEW can choose to commit
   federal funds in a manner inconsistent with a Health Systems Agency's recom-
   mendations. It is hoped, however, that the recommendations by the Health
   Systems Agency would be taken seriously by the Secretary and the State Agency.
   Further, this amendment would require that when the Secretary or State Agency
   makes a decision regarding a grant or contract that is contrary to the
   recommendation of the Health Systems Agency, a written explanation must be
   provided to the applicant and to the Health Systems Agency.

   Planning agencies have been given the responsibility to review proposals to
   determine their consistency with established area-wide health plans, not, we
   believe, to approve or disapprove of projects. As we view it, this difference
   is critical to the planning concept. It keeps the planning agencies in the
   business of planning and out of the realm of regulation. Regulation is
   generally aimed at controlling or limiting, while proper planning activities
   may, in many cases, call for identification of need for new services.

   Unfortunately, because of the subtlety of language and the ambiguity of the
   interpretation, section 1513(c)(1) and (2) is already beginning to compound
   some of the problems of planning. Many planning agencies faced with start-up
   difficulties and inadequate funding have not yet established viable and on-
   going plans to meet the health needs of the community they serve, or at
   best, have only developed simplistic guidelines or formulas. The legislation
   as it now reads will only add complexity to an unrefined or underdeveloped
   process. In addition, although its language separates planning from regulation,
   many planning agencies, and some federal agencies, have already misinterpreted
   this section by translating the phrase "review and comment" to mean review and
   approval or disapproval, and to that extent have undermined the concept of
   planning.

   While we do recognize legitimate and desirable review and comment roles for
   health planning agencies, such review and comment functions can only be
   meaningfully carried out after adequate short and long range plans have been
   developed.

   Planning, as the American Hospital Association interprets the process, should
   not be strengthened through providing planners with authority and responsibility
for regulation, but through strengthening planning capabilities and activities that so far, have been inadequately implemented or totally lacking.

Finally, the regulatory decision, once a judgment of consistency or inconsistency with established plans is made by the planning unit, should rest with a governmental unit, either at the state or federal level. This is the only way in which necessary checks and balances can be maintained, and the only way to bring about orderly change consistent with the available resources.

Therefore, we recommend that this section be amended so that the function is more accurately identified as review and recommendation by the Health Systems Agency.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

**REVIEW FUNCTIONS OF HEALTH SYSTEMS AGENCIES**

**SECTIONS 1513(e)(1) and (2)**

"(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve-or-disapprove make recommendations to the Secretary or, in the case of grants or contracts described in subparagraph (ii) of this paragraph, the appropriate State health planning and development agency on each proposed use within its health service area of Federal funds—  
"(i) 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  
"

"(ii) made available by the State in which the health service area is located from an allotment to the State under an Act referred to in clause (i) for grants or contracts for the development, expansion, or support of health resources.

"(B) A health systems agency shall not review and approve-or-disapprove make recommendations on the proposed use within its health service area of Federal funds appropriated for grants or contracts under title IV, VII, or VIII of this Act unless the grants or contracts are to be made, entered into, or used to support the development of health resources intended for use in the health service area or the delivery of health services. In the case of a proposed use within the health service area of a health systems agency of Federal funds described in subparagraph (A) by an Indian tribe or inter-tribal Indian Organization for any program or project which will be located within or will specifically serve—  
"

"(i) a federally-recognized Indian reservation,  
"(ii) any land area in Oklahoma which is held in trust by the United States for Indians or which is restricted Indian-owned land area, or  
"(iii) a Native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act),  

a health systems agency shall only review and comment on such proposed use.
"(2) Notwithstanding any other provision of this Act or any other Act referred to in paragraph (1), the Secretary shall allow a health systems agency sixty days to make the review and recommendations required by such paragraph. If an agency disapproves recommends against a proposed use in its health service area of Federal funds described in paragraph (1)(A)(1), the Secretary may not make such Federal funds available for such use until he has made, upon request of the entity making such proposal, a review of the agency's disapproval recommendations. In making any such review of any agency's disapproval recommendations, the Secretary shall give the appropriate State health planning and development agency an opportunity to consider the disapproval recommendations of the health systems agency and to submit to the Secretary its comments on the disapproval recommendations. The Secretary, after taking into consideration such State agency's comments (if any), may make such Federal funds available for such use, notwithstanding the disapproved recommendations of the health systems agency. Each such decision by the Secretary to make funds available shall be submitted to the appropriate health systems agency and State health planning and development agency and shall contain a detailed statement of the reasons for the decision, including the comments, if any, of the State agency."
4. Review Functions of Statewide Health Coordinating Councils
Section 1524(c)(6)

a. Policy Position. The American Hospital Association supports an amendment that Statewide Health Coordinating Councils are advisory Councils and would make recommendations to the Secretary.

b. Rationale. This amendment corresponds with the prior amendment regarding the review functions of Health Systems Agencies (see section 1513(e)(1)(2)).
This would make the review functions of the Statewide Health Coordinating Council advisory only. The Councils could neither commit federal funds nor deny them. Like the Health Systems Agency, the Statewide Health Coordinating Council, or SHCC, is a planning agency, and its function in the review and approval process should be advisory only. Further, when the HEW Secretary or State Agency makes a decision regarding a grant or contract contrary to the recommendation of the Statewide Health Coordinating Council, we recommend that HEW provide a written explanation to the applicant as well as to the Health Systems Agency.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

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REVIEW FUNCTIONS OF STATEWIDE HEALTH COORDINATING COUNCILS

SECTION 1524(c)(6)

"(c) A SHCC shall perform the following functions:

"(6) Review annually and approve-or-disapprove make recommendations to the Secretary on any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. Notwithstanding any other provision of this Act or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review and recommendations required by such sentence. If a SHCC disapproves or recommends against such a State plan or application, the Secretary may not make Federal funds available under such State plan or application until he has made, upon request of the Governor of the State, which submitted such plan or application or another agency of such State, a review of the SHCC's decision recommendations. If after such review the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision."
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5. Elimination of Grant Making Function of Health Systems Agencies
   Section 1513(c)(3)
   
a. Policy Position. The American Hospital Association supports an amendment that
   would convert the Area Health Services Development Fund to the State Health
   Services Development Fund, to be administered by the designated State Agency.
   
b. Rationale. The purpose of this amendment is to eliminate the grant-making
   function from the functions mandated for a Health Systems Agency (HSA).
   Instead, Health Systems Agencies would solicit proposals from individuals,
   public and non-profit private entities. These proposals would assist the
   Health Systems Agencies in planning and developing projects and programs
   which they deem necessary for the achievement of the goals described in
   their health systems plans and annual implementation plans. The proposals
   would then be submitted to the State Health Planning and Development
   Agencies, which would be responsible for selecting and funding the proposals.

   We disagree with the assignment to Health System Agencies of direct
   developmental assistance functions. However, we are in agreement that a
   developmental assistance function is necessary and should be supported by
   federal funds. We believe that this activity should be the responsibility
   of the State Agency. Health Systems Agencies' planning functions should be
   limited to reviewing and making recommendations on developmental proposals
   in light of the established plans. To provide Health Systems Agency planners
   with resources to implement their own plans, would detract from the principal
   function of the planning agency. Health Systems Agencies are more
   appropriately advisory to another agency. When development funds are at the
   local level, a conflict of interest may well be unavoidable. For instance,
   a problem may arise when Area Health Services Development Fund support is
   sought for activities which may result in projects or programs which will
   require an eventual formal review by the Health Systems Agency that underwrote
   its planning. The Health Systems Agency would then be presented with the
   inherent conflict of having to review objectively a proposal which was planned
   with Area Health Services Development Funds made available by the Health Systems
   Agency, but the Health Systems Agency would also have to face the possibility that,
   when presented with the details of the proposal listed in the annual implementa-
   tion plan, it would refuse its endorsement and thereby repudiate its own
   plan. It might also be noted that the danger of litigation would be real if
   entities in the community make a major investment of their time and material
   resources in the development of a project which is listed in the annual
   implementation plan and/or stimulated by the award of Area Health Services
   Development Fund monies to underwrite its planning but then failed to receive
   Health Systems Agency endorsement and a certificate of need. These dangers, it
   would seem, would be eliminated if health services development funds were
   specifically limited to planning for projects already endorsed by the Health
   Systems Agency review procedures and to planning activities of the kind that
   would not result in proposals requiring Health Systems Agency review.
Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

ELIMINATION OF THE GRANT MAKING FUNCTION OF HEALTH SYSTEMS AGENCIES
SECTION 1513(c)(3)

"(c) A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(3) The agency shall, in accordance with the priorities established in the AIP, make grants to public and nonprofit private entities and enter into contracts with solicit proposals from individuals and 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. The proposals shall be submitted with the agency's review and recommendations to the State health planning and developing agency. Such grants or contracts shall be made from the Area Health Services Development Fund of the agency established with funds provided under grants made under section 1446. No grants or contracts under this subsection may be used to pay the costs incurred by an entity or individual in the delivery of health services (as defined in regulations of the Secretary) or for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this paragraph shall be available for obligation beyond the one-year period beginning on the date the grant or contract was made or entered into. If an individual or entity receives a grant or contract under this paragraph for a project or program, such individual or entity may receive only one more such grant or contract for such project or program."
6. Funding of Proposals by State Agencies
Section 1523(a)(1)

a. Policy Position. The American Hospital Association supports an amendment that would give the grant-making function to State Health Planning and Development Agencies.

b. Rationale. This amendment would authorize State Agencies to provide financial support for implementation of the plans of Health Systems Agencies (HSAs). The financial support would be derived from the State Health Services Development Fund established pursuant to section 1640. As stated earlier, we disagree with the provision of the law mandating Health Systems Agencies to carry on the function of direct developmental assistance. We are in agreement that a developmental assistance function is necessary and should be supported by federal funds. However, the developmental program activity should be the responsibility of a state level agency which would be able to determine statewide priorities and more effectively allocate federal funds. This would also help avoid a conflict for Health Systems Agencies of having to review objectively a proposal which was planned with area health services development funds made available directly by the Health Systems Agency. This problem would be eliminated if development funds were specifically limited to planning for projects already endorsed by the Health Systems Agency's review and procedures or to planning activities of the kind that would not result in proposals requiring Health Systems Agency review.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

FUNDING OF PROPOSALS BY STATE AGENCIES
SECTION 1523(a)(1)

"SEC. 1523. (a) Each State Agency of a State designated under section 1521(b)(3) shall, except as authorized under subsection (b), perform within the State the following functions:

"(1) Conduct the health planning activities of the State and support the implementation of those parts of the State health plan (under section 1524(c) (2)) and the plans of the health systems agencies within the State which relate to the government of the State and to the health care delivery system in the State, through the agencies of State government and through the State Health Services Development Fund established pursuant to section 1640, which have received review and recommendation by the HSA or are not subject to such review and recommendation."
7. State Health Services Development Funds
Section 1640

a. Policy Position. The American Hospital Association supports an amendment to establish a State Health Services Development Fund.

b. Rationale. The purpose of this amendment is to convert the Area Health Service Development Funds into a single State Health Services Development Fund. These funds could be used by State Agencies to make grants and enter into contracts on behalf of the Health Systems Agencies in accordance with section 1523(a)(1). We would envision the state government acting as a trustee for the development funds and that grants would be made only upon the recommendation of the agency which has the agreement with the Secretary for that state function. There are a number of safeguards which may be included, such as a provision that the Health Systems Agency and the State Agency must agree before projects become funded. The role of the Statewide Health Coordinating Council might well be as one of a sounding board.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

STATE HEALTH SERVICES DEVELOPMENT FUNDS
SECTION 1640

"Part F -- Area State Health Services Development Funds"

"Development Grants for Area State Health Services Development Funds"

"SEC. 1640. (a) The Secretary shall make in each fiscal year a grant to each State health planning and development agency in each State, in which there is at least one health systems agency --

"(1) with which there is in effect a designation agreement under section 1515(c),
"(2) which has in effect an HSP and AIP reviewed by the Statewide Health Coordinating Council, and
"(3) which, as determined under the review made under section 1535 (c), is organized and operated in a manner prescribed by section 1512(b) and is performing its functions under section 1513 in a manner satisfactory to the Secretary,

to enable the State agency to establish and maintain an Area State Health Services Development Fund from which it may make grants and enter into contracts in accordance with section 1523(a)(1).
"(b)(1) Except as provided in paragraph (2), the amount of any grant under subsection (a) shall be determined by the Secretary after taking into consideration the population of the health service area for which the health systems-agency is designated within the State, the average family income of the area State, and the supply of health services in the area State.

"(2) The amount of any grant under subsection (a) to a health systems State agency for any fiscal year may not exceed the product of $1 and the population of the health service area for which such agency is designated State."
8. Schedules for Project Reviews.
   Section 1532(b)

a. Policy Position. The American Hospital Association supports an amendment to
   P.L. 89-471, which would require that project reviews under state certificate
   of need laws and section 1122 of the Social Security Act be completed within
   90 days of submission of complete information concerning a project, with the
   project being deemed to be approved if it is not rejected within that time
   period.

b. Rationale. In prescribing procedures to be followed in conducting project
   reviews under section 1122, the Secretary of HHS provided that projects
   would be deemed to be approved unless they were specifically disapproved by
   the designated planning agency within 90 days from the date that complete
   information concerning such projects was submitted. That regulation has worked
   well in the five years that section 1122 has been in place. Its effect has been
   to force the reviewing agencies to rule upon applications with dispatch and
   to provide written explanation for every negative decision.

In promulgating regulations setting forth minimum standards for state certi-
   ficate of need laws, the Secretary reversed that presumption. The original
   draft regulations, published for public comment on March 19, 1976, did not
   specify the effect of inaction by the state agency, although section 1122
   regulations which were republished at that time continued the "approval by
   silence" rule for those reviews.

However, without explanation and without reference to any comments received
   from the public an inconsistent rule was adopted with respect to the re-
   quirements for state laws. Section 125.407(a)(15) of the regulations man-
   dates that state laws provide that "if the state agency does not make a
   decision regarding a proposed new institutional health service within a
   period of time specified for state agency review, the proposal shall be
   deemed to have been found not to be needed." This complete turnaround
   mandates a startling inconsistency between section 1122 procedures and
   those required for state certificate of need laws. Thus, a project might
   be deemed to be approved for federal reimbursement but be deemed to be
   disapproved under state law. Grave uncertainty would result from this
   situation.

More important than mere inconsistency, however, is the fact that the
   Secretary's new position permits, for the first time, imposition of a
   "pocket veto" on a project, without any need on the part of the state
   agency to provide a written explanation of its action. Since project
   sponsors have been granted the right of appeal and a fair hearing, they
   must decide whether or not to appeal without knowledge of the reasons
   that their applications have been denied. It is doubtful that a "fair
   hearing" can in fact be provided unless the reason for the action being
   appealed has been made known. Due process questions arise from such
   a "pocket veto".

Serious discredit could be brought to the planning process by continued
   use of the "pocket veto". It encourages unnecessary delay and secrecy
   and can substantially handicap both public and provider understanding
   of the reasons behind agency actions. In the present inflationary
environment, every month of delay in reaching decisions on proposed projects adds perceptibly to the cost of such projects. Federal policy should encourage prompt action and openness in the planning process.

c. Legislative Language. The following legislative changes are proposed:

Procedures and Criteria for Reviews of Proposed Health Systems

"Sec. 1532

***(b) Each health systems agency and State Agency shall include in the procedures required by subsection (a) at least the following:

"(1) Written notification to affected persons of the beginning of a review, which shall be given within five days of the date that all information described in paragraph (3) is submitted."

"(2) Schedules for reviews conducted in discharge of the functions described in paragraph (4) of subsection 1523 (a) which provide that no such review shall, to the extent practicable, except with the consent of the person subject to such review, take longer than ninety days from the date that the notification described in paragraph (1) is made. Failure of the State Agency to act on a proposal within such period shall be deemed to constitute approval of such proposal."
9. Hearings for Project Reviews at State and Local Levels
Sections 1532(b), 1532(a) and 1532(b)

a. Policy Position. American Hospital Association supports an amendment to the National Health Planning and Resources Development Act to require a public forum for all interested parties who desire to participate in project reviews at the local level and to permit either the HSA or the applicant to request a formal hearing prior to any decision being made at the state level in a certificate of need or Section 1122 project review or in a review of the appropriateness of institutional health services.

b. Rationale. Although Section 1532(8) of the statute requires public hearings during the course of project reviews and appropriateness reviews, it is vague as to the stage of the proceedings at which such hearings shall take place. There is also a requirement for public hearings "for good cause shown" after HSA and State Agency decisions, but, again, the timing and location are not specified. We suggest that it would be appropriate to provide for one public hearing at the local level, at which all interested persons would have the opportunity to make statements or present evidence with respect to the application or other review. To provide the maximum opportunity for such participation, such a hearing should be well publicized, informal in nature and conducted in the local community. A summary, although not a verbatim transcript, should be made, which should become part of the record of the total review process, and form part of the basis for the recommendations of the HSA and the decisions of the State Agency.

A second public hearing would generally tend to be merely repetitious of the statements and comments made at the first. However, there ought to be an opportunity for either the applicant or the HSA to request a formal hearing conducted by the State Agency prior to its decision. The interests of fairness and equity then would require that the decision be appealable by either party to the formal hearing, to a state agency other than the State Health Planning and Development Agency and thence to the courts to the extent provided by state law. At present, such an appeal is provided to the health systems agency only if the SHPDA decision is inconsistent with HSA recommendations. The existence of a right of appeal on the part of a project sponsor depends upon state law and on whether review is being conducted under Section 1122 of the Social Security Act or under a state certificate of need program. There are no provisions for institutions to appeal adverse findings made in the course of appropriateness reviews, even though these can have serious detrimental effects.

The amendments proposed will: (i) consolidate all the P.L.23-641 requirements for review procedures into Section 1532, where the bulk of them now appear; (ii) require that the procedures for the different kinds of reviews be harmonized, to the extent permitted by the statutes under which the reviews are being conducted, making it clear that the regulatory process must not contravene statutory requirements; (iii) provide for a public forum to be conducted by the health systems agency, at which all interested persons may appear and present statements or evidence concerning the review being conducted; (iv) require a formal hearing prior to the decision of the State Agency, at the request of either the health systems agency or the sponsor of a project or the institution whose services are being reviewed for their appropriateness.
c. Legislative Language. The following specific legislative language is proposed to accomplish the changes in the National Health Planning and Resources Development Act set forth above.

HEARINGS AND PROCEDURES

SECTIONS 1522(b), 1532(a) and 1532(b)

"State Administrative Program"

"Section 1522(b). The State Program of a State must --

(13) provide that if the State Agency makes a decision, in the performance of a function under paragraph (9), (4), (5), or (6) of Section 1533(a), or under title XVI which is inconsistent with a recommendation made under Section 1533(b), (g), or (h) of Section 1533 by a health systems agency with the State --

(A) such decision (and the record upon which it was made) shall, upon request of the health systems agency, be reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the State health planning and development agency designated by the Governor), and

(B) the decision of the reviewing agency shall for purposes of this title and title XVI be considered the decision of the State health planning and development agency."

"Procedures and Criteria for Reviews of Proposed Health System Changes"

"Section 1532. (a) In conducting reviews pursuant to Subsections (e), (f), and (g) of Section 1513 or in conducting any other reviews of proposed 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 in accordance with regulations of the Secretary; and in performing its review functions under Section 1523, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary. Procedures and criteria for reviews by health systems agencies and States Agencies must be in accordance with the State and Federal statutes pursuant to which such reviews are being conducted, but may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

(b) Each health systems agency and State Agency shall include in the procedures required by Subsection (a) at least the following:
(8) Provision for public hearings in the course of agency review at which members of the public shall have opportunity to make statements and present relevant evidence; or provision for formal hearings to be conducted by the State Agency if requested by persons directly affected by the review; the agency or the entity proposing the project or whose services are being reviewed; and provision for public hearings, for good-cause shown, respecting agency and State Agency decisions; review of any decision by a State Agency in any matter subject to Subsection 1332(a) at the request of the health systems agency or of the entity offering or proposing to offer the services being reviewed, under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies, by an agency of the State (other than the state health planning and development agency) designated by the Governor and, to the extent provided by State law, to the courts of the state. The decision of the reviewing agency or court shall, for purposes of this title, title XVI and Section 1122 of the Social Security Act be considered the decision of the state health planning and development agency.
10. Phase In of Functions of Health Systems Agencies
   Section 1513(b)

   a. Policy Position. The American Hospital Association supports an amendment to
      ensure that agencies do not perform functions which are beyond their capability.

   b. Rationale. The purpose of this amendment is to permit Health Systems Agency (HSA)
      functions to be phased in, in accordance with staff expertise and availability of
      funds. DHEW should evaluate each applicant's proposed work program according to
      the agency's level of expertise and financing. The magnitude of the tasks listed
      as functions of a Health Systems Agency is overwhelming. If Health Systems
      Agencies are permitted to phase-in their programs in an orderly manner, and are
      not mandated to attempt to perform functions that are beyond their capabilities
      and available resources, the credibility and effectiveness of the Health Systems
      Agencies will be greatly enhanced.

      For example, we have recommended that the appropriateness review functions be
      deleted as it is felt that in the absence of adequate staffing or adequate
      funding a review of this magnitude would be prohibitive. In the event that our
      recommendation for deletion of the appropriateness review is not followed as one
      of the functions of an HSA and State Agency, we believe that this is a prime
      example of a function which should be phased in after all other functions are
      in place. The Health Systems Agencies have numerous tasks to perform. Should
      they try to accomplish all these tasks simultaneously the efforts in each of
      them will be less than satisfactory.

   c. Legislative Language. The following is proposed legislative language to amend
      the National Health Planning and Resources Development Act in accord with the
      above policy:

      PHASE IN FUNCTIONS OF HEALTH SYSTEMS AGENCIES
      SECTION 1513(b)

      "(b) In providing health planning and resources development for its
      health service area, a health systems agency shall perform, to the extent
      that its capabilities and approved work program permit, the following functions:
      
      "(1) The agency shall 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 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."

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      health service area, a health systems agency shall perform, to the extent
      that its capabilities and approved work program permit, the following functions:
      
      "(1) The agency shall 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 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."
11. Composition of National Council on Health Planning and Development

Section 1503(b)(1)

a. Policy Position. The American Hospital Association supports an amendment to ensure hospital representation at the national level.

b. Rationale. As the legislation is now written, there is no provision to ensure adequate representation of hospital provider interests at the national level of the planning structure. Hospitals may therefore, be represented by someone who is not directly involved in health care delivery in hospitals and would not necessarily be in the best position to represent hospital needs. The underlying philosophy of the statute is that health care policy is to be developed through a coalition of representative consumer and provider interests. Because the nature of the representation categories is so broad and the various provider categories are so extensive, the possibility exists that the National Council could be composed of providers excluding a hospital representative unless there is specification that one of the five provider categories as listed in section 1512(b)(3)(C)(ii) should be a person who is a hospital representative. As this is a major category for the provision of health service, it is important to preclude this possibility.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

COMPOSITION OF NATIONAL COUNCIL ON HEALTH PLANNING AND DEVELOPMENT

SECTION 1503(b)(1)

"(b)(1) The Council shall be composed of not less than fifteen nor more than twenty members. The Chief Medical Director of the Veteran's Administration, the Assistant Secretary for Health and Environment of the Department of Defense, and the Assistant Secretary for Health of the Department of Health, Education, and Welfare shall be nonvoting ex officio members of the Council. The remaining members shall be appointed by the Secretary and shall be persons who, as a result of their training, experience, or attainments, are exceptionally well qualified to assist in carrying out the functions of the Council. Of the voting members, not less than one shall represent each of the five classifications of providers enumerated in section 1512(b)(3)(C)(ii), not less than five shall be persons who are not providers of health services, not more than three shall be officers or employees of the Federal Government, not less than three shall be members of governing bodies of health systems agencies designated under part B, and not less than three shall be members of Statewide Health Coordinating Councils under section 1524 and not less than one shall be representative of hospital administration. The two major political parties shall have equal representation among the voting members on the Council."

12. Composition of Statewide Health Coordinating Councils
Section 1524(b)(1)(C)

a. Policy Position. The American Hospital Association supports an amendment to ensure hospital representation at the state level and to increase the proportion of direct providers at the state level.

b. Rationale. As the legislation is now written, there is no provision to ensure adequate representation of hospital provider interests at the state level of the planning structure. Hospitals may therefore, be represented by someone who is not directly involved in health care delivery in hospitals and would not necessarily be in the best position to represent hospital needs. The underlying philosophy of the statute is that health care policy is to be developed through a coalition of representative consumer and provider interests. Because the nature of the representation categories is so broad and the various provider categories are so extensive, the possibility exists that the Statewide Health Coordinating Council could be composed of providers excluding a hospital representative unless there is specification that one of the five provider categories as listed in section 1512(b)(3)(C)(i) should be a person who is a hospital representative. As this is a major category for the provision of health service, it is important to preclude this possibility.

In addition, this amendment is to increase the proportion of direct providers of health care on the Statewide Health Coordinating Council (SHCC) from one-third of the providers of health care to one-half. The importance of provider input to the decision making activities of the Statewide Health Coordinating Council cannot be too greatly emphasized. Because of the variance between the definition of those persons classified as indirect providers and those classified as direct providers, it is imperative to have the health care field adequately represented by those who do in fact directly provide health care services.

The amendment to increase direct providers on the Statewide Health Coordinating Council is consistent with our strong belief that health care and hospital membership at the national, state and local level should be appropriately represented. We believe a ratio of one-third direct provider and two-thirds indirect provider is an equitable balance.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development in accord with the above policy:

COMPOSITION OF STATEWIDE HEALTH COORDINATING COUNCILS

SECTION 1524(b)(1)(C)

"(C) Not less than one-third one-half of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 1531(3)), and not less than one representative of each of the classifications of providers enumerated in section 1512(b)(3)(C)(i) shall be represented on the SHCC of whom at least one shall be representative of hospital administration."
13. HSA Board Membership Requirements
Section 1512 (b)(3)

a. Policy Position. The American Hospital Association supports an amendment to Public Law 93-641 modifying the existing demographic quotas for membership on the boards of health systems agencies by substituting more general criteria which will assure the appointment of knowledgeable, qualified and interested individuals.

b. Rationale. Planning is a judgmental process. Research and evaluation based on sound quantitative data can help to clarify the options available. But no amount of data can eliminate the need for planning agencies to exercise judgment in choosing among competing uses of resources. The critically important element in the effectiveness of the entire process is the calibre of the HSA board members who must in the final analysis make the difficult decisions.

It is appropriate that the law require consumer majorities on planning bodies. However, demands that social, economic, linguistic, and racial population of the area be proportionately represented on HSA boards have spawned confusion and litigation. Attempts to secure proportionate representation of all such groups have hampered efforts to assure widespread public participation in the selection of board and advisory group members and have sometimes created bodies that sacrifice sound decision making to demands for full participation.

In some cases, it has seemed that board members were selected primarily to fill a numerical quota for a social or economic population rather than on the basis of merit and interest. Frequently, individuals selected have been unqualified as planners, uninformed about health care delivery, or preoccupied by personal interests. The process of selecting individuals primarily on the basis of their consumer advocacy background or to fill an ethnic quota must be replaced by a more systematic and deliberative process. The current requirements for HSA boards should be supplemented with criteria based on knowledge, record of community achievement, objectivity, expertise in health care delivery, and familiarity with community needs. For practical and political credibility, highly knowledgeable individuals must be selected.

It is, however, consistent with the intent of the statute and with practical necessities to mandate representation of the major types of providers who are affected by the planning process. The principal impact of the statute is intended to be upon providers of major institutional services -- for the most part, upon hospitals. To avoid turning the entire process into a confrontation between adversaries, it is essential that the views of those charged with administration of hospitals be represented on the planning boards. It should also be recognized that hospitals are themselves complex institutions in which many apparently diverse interests must be reconciled. No hospital can afford to ignore the needs and interests of its medical staff, its nurses, its technicians and other practitioners, its non-professional employees, or its patients. For these reasons, we have urged that the hospital representation on such boards be assured by statutory provisions.

The size of the HSA board membership may also tend to defeat or complicate planning. Current requirements state that an HSA governing board must have a minimum membership of 10 but that, if it has more than 30, an executive committee must be formed. A preliminary review indicates that more than half of these governing bodies have more than 30 members. Because of the difficulties in obtaining useful deliberations from large groups, these boards may be too cumbersome to function effectively or to promote a sense of individual responsibility. If the size of HSA boards were reduced, the quality of
deliberation and the resulting decisions might improve. In addition, capable individuals might be more inclined to accept appointment to small boards in which their participation would carry greater weight and individual contributions would receive greater recognition.

c. Legislative Language. The following legislative language is proposed:

"(3) Governing Body --

"(A) In General. -- A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, have a governing body for health planning, which is established in accordance with sub-paragraph (C), which shall have the responsibilities prescribed by subparagraph (B), and which has exclusive authority to perform for the agency the functions described in Section 1513. Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an "executive committee") composed, in accordance with subparagraph (C) of not more than twenty-five members of the governing body and has delegated to that unit the authority to take such action other than the establishment and revision of the plans referred to in subparagraph (B)(ii) as the governing body is authorized to take.

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"(C) Composition. -- The membership of the governing body and the executive committee (if any) of an agency shall be individuals who reside or have their principal place of business or employment in the health service area served by the agency, who are chosen on the basis of their knowledge and experience in the delivery of health care, their familiarity with the needs and interests of one or more communities within the health service area served by the agency, their objectivity, their record of achievement in the community and their sense of individual responsibility. Subject to the foregoing qualifications, efforts should be made to meet the following requirements goals for representation on the board or executive committee:

"(A) A majority (but not more than 50 per cent of the members) shall be residents of the health service area served by the entity who are consumers of health care and who are not (nor were within the twelve months preceding appointment been) providers of health care and who are broadly representative of the major social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care, including insurers who do not provide health care to the public or to their members, subscribers or policyholders directly or through subsidiaries or affiliates.
"(ii) The remainder of the members shall be residents-of-the-health service area served by the agency who are providers of health care broadly representative of one or more of the following categories: (I) physicians (particularly practicing physicians), dentists, nurses, and other health professionals, (II) hospitals and other health care institutions (particularly hospitals such as long-term care facilities and health maintenance organizations), (III) health-care insurers, (IV) health professional schools, and (V) the allied health professions. Not less than one-third of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in Section 1531 (3)) and not less than one of whom shall represent hospital administration.

"(iii) The membership shall —

"(I) include (either through consumer or provider members) one or more public elected officials and other representatives of government authorities in the agency's health service area and representatives of public and private agencies in the area concerned with health.

"(II) include a percentage of individuals who reside in non-metropolitan areas within the health service area which percentage is equal to the percentage of residents of the area who reside in non-metropolitan areas, and

"(III) if the health systems agency serves an area in which there is located one or more hospitals or other health care facilities of the Veterans' Administration, include, as an ex officio member, an individual whom the Chief Medical Director of the Veterans' Administration shall have designated for such purpose and if the agency serves an area in which there is located one or more qualified health maintenance organizations (within the meaning of Section 1310), include at least one member who is representative of such organizations.

"(iv) If, in the exercise of its functions, a governing body or executive committee appoints a subcommittee of its members or an advisory group, it shall, to the extent practicable, make its appointments to any such subcommittee or group in such a manner as to provide the representation on such subcommittee or group described in this subparagraph."
14. Indirect Providers of Health Care
Section 1531(3)

a. Policy Position. The American Hospital Association supports an amendment to restrict the definition of "indirect providers" to persons whose interests are closely allied to direct providers.

b. Rationale. This amendment has the effect of shifting back into the consumer classification some individuals and organizations that are presently misclassified as providers, under the quotas established for planning agencies boards. We believe the statutory definition of "indirect provider" goes to an unwarranted extreme to assure that persons who are directly tied to the interests of health care services do not serve as "consumer" representatives. Persons, who are, in fact, non-providers with only coincidental or indirect ties to the health system and some who occasionally have direct conflicts with providers are presently included in the classification of "indirect providers." We urge that such persons and organizations should be qualified to serve as consumer representatives.

Accordingly, the American Hospital Association recommends that the definition of "indirect provider" not include (i) members of the immediate family of an indirect provider, (ii) any individual who receives less than one-quarter of his gross income from health care interest or direct providers, (iii) organizations which are basically concerned with education and research in aspects of particular diseases, such as the Heart Fund or the National Foundation, or (iv) insurers which do not provide health services to the public, either directly or through affiliates or subsidiaries.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act to limit the definition of indirect provider:

INDIRECT PROVIDERS OF HEALTH CARE
SECTION 1531(3)

"(3) The term 'provider of health care' means an individual —
** **

(3) who is an indirect provider of health care in that the individual —

(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II), or (IV) or (V) of clause (II);

(II) receives (either directly or not through his or her spouse or other family member) more than one-seventh one-quarter of his gross annual income from any one or combination of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care;

(II) Entities engaged-in-the-provision-of-health-care-or-in which conduct such research or instruction, but not including entities which are engaged primarily in research and public education concerning special health issues or services or the detection, treatment and prevention of one or more specific diseases or physical disabilities.
(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research care.

(IV) Entities engaged in producing drugs or such other articles.

(V) Entities engaged in the provision of health care services to the public or to their members, subscribers or policyholders either directly or through subsidiaries or affiliates, including health maintenance organizations.

(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii) or (iv) of subparagraph (b) or

(iv) is engaged in issuing any policy or contract of individual or group insurance or hospital or medical service benefits.
15. Appropriateness Review by Health Systems Agencies, Section 1513 (g)(1) and (2) Appropriateness Review by State Agencies, Section 1523(a)(6)

a. Policy Position. The American Hospital Association supports an amendment that would delete appropriateness review from the functions of Health Systems Agencies and State Health Planning and Development Agencies.

b. Rationale. We suggest that the appropriateness review sections in P.L. 93-641 are unnecessary and should be deleted from the law. Those sections have not yet been defined or developed by HHS regulations, a reflection on one of the difficulties that is created by this provision. No one has been able to come up with an acceptable definition of this function, nor have standards and guidelines been developed to assist HSAs and state agencies in implementing this function. In addition, many planning experts have expressed the viewpoint that HSAs and state agencies cannot effectively implement this provision.

Another problem is created by the fact that the law now requires that health systems agencies and state agencies individually review, on a periodic basis, each service and facility within the area of the state to determine their appropriateness. The magnitude of this burden can be appreciated when one considers that there are over 7,000 hospitals, many of which provide a broad range of services, over 22,000 nursing homes, and many other institutional providers, all of which would require appropriateness review. We believe that such a requirement adds an impossible burden on an already overworked process.

Congress incorporated this provision in P.L. 93-641 in an attempt to deal with the problem of duplicative facilities and services. It is our view that a more effective and comprehensive planning and certification of need process can serve as the mechanisms to eliminate unneeded facilities and services on a planned and rational basis. A sound preparation of health systems plans should include assessment of the appropriateness of facilities and services, not as a review function but as part of the planning process. The certificate of need function at the state level can also deal with this problem where it is determined to exist. Further, there are other legislative authorities that have a positive impact on the problem, e.g., PPSO, rate review, and utilization review at the hospital level. We therefore recommend the deletion of appropriateness review from the functions of health systems agencies detailed in Section 1513(g) and state health planning and development agencies as stated in Section 1523(a).

c. Legislative Language. The following is the legislative language we propose to delete from the National Health Planning and Resources Development Act:

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APPROPRIATENESS REVIEW BY HEALTH SYSTEMS AGENCIES
SECTION 1513(g)(1) and (2)

"(g)(1) Except as provided in paragraph (2), each health systems agency shall review on a periodic basis (but at least every five years) all institutional health services offered in the health service area of the agency and shall make recommendations to the State health planning and development agency designated under section 1523 for each State in which the health systems agency's health service area is located respecting the appropriateness in the area of such services.
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(f) A health-systems-agency shall complete its initial review of existing institutional-health-services within three years after the date of the agencies designation under section 1512(e).

APPROPRIATENESS REVIEW BY STATE AGENCIES

SECTION 1523(a)(6)

"(6) Review on a periodic basis (but not less often than every five years) all institutional health services being offered in the State and, after consideration of recommendations submitted by health-systems-agencies under section 1512(g), respecting the propriateness of such services, make public its findings.

(f) A State Agency shall complete its findings with respect to the appropriateness of any existing institutional health service within one year after the date a health-systems-agency has made its recommendation under section 1523(g), with respect to the appropriateness of the service.

(a) If a State Agency makes a decision in carrying out a function described in paragraph (4), (5), (6) or (f) of subsection (a) which is not consistent with the goals of the applicable ESP or the priorities of the applicable AIF, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency."
16. Federal Hospital Construction Requirements
Section 1602

a. Policy Position. The federal government should develop a single set of codes and standards for the physical requirements of hospitals and other institutional providers of health care which would apply under all federal programs that stipulate compliance with facility codes and standards as requirements for participation, to which state and local governments should be encouraged to adhere as well.

b. Rationale. The facilities in which hospital care or other institutional health care is provided are frequently subject to regulation from a multiplicity of agencies. State agencies are often granted such authority through certification or licensure laws, local authorities enforce building and sanitation codes, and federal agencies such as Medicare and the Federal Housing Authority often impose compliance with construction standards as a condition for participation in the program. These requirements are not always consistent with each other. In some cases, the institution may be able to conform to the more restrictive requirements, thus satisfying both, but in other cases it must decide which of the conflicting requirements will be satisfied, a decision usually based on the likely legal consequences of failure to satisfy the other.

This climate of multiple, often conflicting, codes has sometimes resulted in frustration and confusion, not only for the institutions, but also for architects, planning authorities and even the agencies which have adopted and are charged with enforcing the conflicting codes. Further complicating the situation is the fact that new codes are constantly under development and old ones are subject to frequent revisions. Different authorities having jurisdiction often enforce different revisions. Multiple codes produce added costs for institutions which are ultimately passed on to their patients and third party payors.

The American Hospital Association believes that the federal government should take the lead in resolving this situation. First, the federal government should require that all federal programs that include codes and standards for physical facilities as requirements for participation should have consistent or identical standards. State and local authorities and voluntary accreditation or certification bodies should be urged to adopt the federal standards as their own. Even though there may be a demonstrated need for different emphasis in different parts of the country because of substantive geographical or environmental differences, these differences can generally be accommodated by permitting state and local authorities to impose additional but not conflicting, requirements or waivers to accommodate hazards or lack of hazards from earthquakes, hurricanes, blizzards and the like.

In development of uniform physical facility standards, maximum opportunity should be provided to all interested persons for input into the standardization of fire, safety, sanitary, electrical and other requirements. In addition, there is a need for a mechanism by which individual institutions can obtain determinations regarding appropriate requirements, use of equivalencies and adequate time allowances related to compliance with new codes. At any given time, many existing buildings are not in full compliance with all provisions of current codes. The differences between the standards met and the newest requirements are frequently small, but the cost of meeting the latest standards may be quite high, without commensurate benefit to the public interest. It must also be noted that the cheapest initial construction is not always the most economical, in view of maintenance and other operating costs which can
be raised substantially as a result of initial economies in design and construction.

c. Legislative Language. The American Hospital Association supports the following amendment to the National Health Planning and Resources Development Act, adding a new Section 1602(h) to meet the above objectives.

"General Regulations

"Section 1602(a) The Secretary shall be regulation —

"(2) prescribe for medical facilities projects assisted under this title, general standards of construction, modernization, and equipment for medical facilities of different classes and in different types of location;

"(4) prescribe criteria for determining the extent to which existing medical facilities are in need of modernization;

"(b) In promulgating the regulations required by paragraphs (2) and (4) above, the Secretary shall —

"(1) Consult with and solicit recommendations and comments from (a) the agencies and other entities described in Section 1501(c) of title XV, (B) Federal and State agencies which have issued guidelines, recommendations, criteria, standards, or requirements respecting the physical aspects of medical facilities, (C) private entities which have promulgated standards, codes, or guidelines with respect to fire, infection, electrical or safety hazards, (D) the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association and any other private entities which have established voluntary licensure or accreditation standards for health care facilities.

"(2) Within six months of enactment hereof, issue proposed regulations which will give consideration to the recommendations provided by the entities listed in (1) and which are capable of being adopted by all such agencies as uniform standards for the construction, modernization and equipment of medical facilities, whether or not such facilities are eligible for assistance under this title. Such proposed regulations shall allow a reasonable time for submission of comments by the public and the entities listed in (1).

"(3) Within one year after the date of enactment hereof, issue final regulations.

"(4) Urge adoption of the regulatory standards for construction, modernization and equipment by all agencies and entities listed in (1), to the fullest extent practicable. Such adoption shall be mandatory for
all Federal agencies identified in (1) above, including without limitation, the Federal Housing Authority, the Occupational Safety and Health Administration, the Veterans Administration, the Public Health Service and the Indian Health Service.

"(5) Such standards shall make provision for the imposition by State and local agencies of additional or higher standards deemed necessary to meet substantially different local geographic or environmental conditions, such as susceptibility to earthquakes, floods and other natural phenomena, but no other inconsistent or more restrictive standards shall be imposed upon any project which is eligible for assistance under this title.

"(6) Require, to the maximum extent feasible, joint or consolidated inspection and enforcement activities by all entities described in (1).

"(7) Provide in such regulations for the issuance of advisory determinations concerning compliance with the requirements through the use of equivalencies and alternatives. Such regulations shall state specifically the degree to which existing facilities shall be required to meet new requirements and standards and shall establish appropriate time allowances for achieving such compliance. The regulations shall specify the degree to which modernization projects shall be required to meet the requirements and standards for new construction.

"(8) Provide for review on a periodic basis (but at least every three years) of the standards and requirements contained in such regulations.
17. Provision of Free Care
Section 1604(b)(1)(J)

a. Policy Position. The American Hospital Association supports an amendment to clarify the obligations of health care institutions which receive certain federal funds.

b. Rationale. The purpose of this amendment is to make more reasonable the obligation of health care institutions which receive certain federal funds to make health care available to patients unable to pay.

The amendment requires that such facilities provide reasonable assurance for such health care for a period of 20 years after the approval of their funding applications if a grant, or the length of time of the loan or loan guaranteed assistance. It also limits the facility's obligation to those persons residing or employed within its service area. Finally, the amendment makes enforcement of this obligation a responsibility of the State Agency under the terms of its agreement with the Secretary, as is the case with other provisions of this part of the Act.

While hospitals have provided and will continue to provide services to individuals unable to pay for care, the accountability for providing a reasonable volume of uncompensated services in section 1604(b)(1)(g)(ii) should be limited to the existing 20 year period for the recovery of assistance funds found under Title VI of the Public Health Service Act.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy.

PROVISION OF FREE CARE
SECTION 1604 (b)(1)(J)

"(J) reasonable assurance that at all times for a period of twenty years after such application is approved if a grant, for the length of time of the loan or loan guarantee assistance, (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility's service area and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint."
Planning Grants for Health Systems Agencies
Section 1516(b)(1), (2)(B), and (3)

a. Policy Position. The American Hospital Association supports an amendment to increase funding for fully designated and conditionally designated Health Systems Agencies.

b. Rationale. We support an amendment that would increase the minimum amount a Health Systems Agency (HSA) receives for full designation and to specify that conditionally designated Health Systems Agencies are to be funded at the same levels as fully designated Health Systems Agencies. We would encourage that the amount to be awarded per person per year be increased from 50¢ to 55¢ during the fiscal year 1978, from 55¢ to 60¢ during the fiscal year 1979, and from 60¢ to 70¢ during the fiscal year 1980. These changes would reflect inflationary costs, for a total amount of $4,500,000 unless the agency would receive a greater amount based upon population. In addition, we propose that the amount of a grant for a Health Systems Agency may not be less than $185,000, an increase from the proposed $175,000 (again, to reflect inflation). The purpose of the amendment is to ensure that Health Systems Agencies conditionally designated are able to perform in an effective manner. We strongly recommend that appropriations for this activity be considered in the light of a new program, which is in a critical stage of development. We urge that funding levels provide the necessary resources for the sound development of this program across the country.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

"PLANNING GRANTS FOR HEALTH SYSTEMS AGENCIES
SECTION 1516(b)(1), (2)(B), and (3)

"(b)(1) The amount of any grant under subsection (a) to a health systems agency designated under section 1516(b) shall be determined by the Secretary the amount of any grant under subsection (a) to any health systems agency designated under section 1516(b) and shall be the lesser of (A) the product of $0.55 during the fiscal year 1978, $0.60 during the fiscal year 1979, and $0.70 during the fiscal year 1980 and the population of the health service area for which the agency is designated, or (B) $3,500,000.

unless the agency would receive a greater amount under paragraph (2) or (3).

"(2)(B) The non-Federal funds which an agency may use for the purpose of obtaining a grant under subsection (a) which is computed on the basis of the formula prescribed by subparagraph (A) shall --

"(i) not include any funds contributed to the agency by any individual or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of operation of health resources of the kind that may be within the purview of the agency's functions under subsections 1513(c), (f), and (g), and

"(ii) be funds which are not paid to the agency for the performance of particular services by it and which are otherwise contributed to
the agency without conditions as to their use other than the condition that the funds shall be used for the purposes for which a grant made under this section may be used.

"(3) The amount of a grant under subsection (a) to a health systems agency designated under section 1515(e) may not be less than $175,000 $185,000 during the fiscal year 1978, $195,000 during the fiscal year 1979, and $205,000 during the fiscal year 1980."
19. Private Contributions to Health Systems Agencies
Section 1512(b)(5)

a. Policy Position. The American Hospital Association supports an amendment to increase funding for Health Systems Agencies by permitting a broadened base of non-federal funds for Health Systems Agencies activities.

b. Rationale. The purpose of this amendment is two-fold: First to allow Health Systems Agencies (HSAs) to receive additional matching federal funds and second, to permit a broadened scope of non-federal funds that can be used by the Health Systems Agencies for accomplishing their work programs. As an alternative to the severe limitations now stated in the law, there should be a clarification as to the sources from which a Health Systems Agency cannot accept contributions because of possible benefit from an agency action. Also, if the legislation were changed to read substantial funds or contributions of services, this would have the effect of broadening the funding base without jeopardizing the Health Systems Agency’s actions. It would permit more adequate funding for Health Systems Agency operations.

Every effort should be made to provide for the success of Health Systems Agencies, to further develop the planning process. If only federal funds are to be used, many Health Systems Agencies will not have adequate staff to perform all of their mandated functions.

c. Legislative Language. The following is proposed legislative language to amend the National Health Planning and Resources Development Act in accord with the above policy:

"(5) PRIVATE CONTRIBUTIONS. —No health systems agency may accept more than ten percent (10%) of its operating budget or more than $50,000 in any funds or contributions of services [other than processed data] or facilities from any individual, or private entity which has a financial, fiduciary, or other direct interest in the development, expansion, or support of health resources within the purview of the agency under subsections 1513(c), (f), and (g) unless, in the case of an entity, it is an organization described in section 509(a) of the Internal Revenue Code of 1954 and is not directly engaged in the provision of health care in the health service area of the agency. No health systems agency may accept in the aggregate from all such individuals, associations and private entities more than twenty-five percent (25%) of its operating budget. For purposes of this paragraph, an entity shall not be considered to have such an interest solely on the basis of its providing (directly or indirectly) health care for its employees or health insurance benefits for enrolled subscribers."
20. Uniform Cost Accounting and Reporting Systems
   Section 1533(d) and 1502(9)

   a. Policy Position. The American Hospital Association opposes the establishment of mandatory uniform accounting requirements, but supports uniform reporting of costs, rates and services.

   b. Rationale. Section 1533(d) of the National Health Planning and Resources Development Act calls for the establishment by the Secretary, of uniform systems for cost accounting, establishment of rates, classification of institutions and cost reporting. In the last session of Congress the implementation of a uniform reporting system along with a method of reconciliation the health care institutions' internal accounting systems to the reporting system were enacted through Section 19(a) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act. Since the enactment of this legislation puts in place national systems of Reporting and Reconciliation, this Association believes the need for the continuation of the intent of Section 1533(d) and 1509(a) is no longer necessary or applicable.

   It should be noted that the Association supports the establishment of uniform reporting forms so that health planning and cost reimbursement agencies are enabled to make equitable and valid comparisons among institutions and to design better reimbursement methods and systems. Although uniform accounting might seem theoretically desirable, a mandated system which lacks flexibility when applied to local situations cannot be implemented without impairing management responsibility and accounting innovation. Whenever uniform accounting has been required for an industry, it has been accompanied by an inevitable lag between development of new financial techniques, accounting principles and management information needs. The importance of a flexible accounting system, which will enable institutions to continue to adhere to generally accepted accounting principles as they evolve, cannot be overemphasized. Therefore, the Association supports uniform reporting of costs and services, but does not support extension of that principle to the requirement of uniform accounting for all institutions.

   Uniform reporting, and classification can be, and are acceptable concepts since they need not affect internal accounting systems and management prerogatives in obtaining desired results. The necessary requisite to uniform reporting need only be an adequate method of reconciliation, for conversion of internal accounting information into a uniform reporting system. This does not necessitate uniform accounting. As indicated, both systems—uniform reporting and a system of reconciliation—have already been directed by Congress in its last session.

   The American Hospital Association, therefore, recommends that Section 1533(d) be amended to be consistent with Section 19(a) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act. In addition, we recommend amendment of Section 1502(9) to also be consistent with the new Section of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act.
c. Legislative Language. The following is the legislative language proposed for Section 1502(9) and 1533(d):

**UNIFORM COST-ACCOUNTING-AND REPORTING SYSTEMS**

**SECTION 1502(9)**


**SECTION 1533(d)**

*Note:* Delete all of present Section 1533(d) and substitute the following:

"(d) The Secretary shall, by regulation, implement in accordance to Section 19(a) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142, codified as Section 1121 of the Social Security Act, uniform reporting systems for health services facilities and organizations."
21. Prohibition Against Purchasers of Health Care Being Designated as Health Systems Agency
   Section 1512(b)(1)

a. Policy Position. The American Hospital Association supports an amendment to P.L. 95-641 which would eliminate the possibility that a major purchaser or provider of health services could be appointed to act as a health systems agency, thus avoiding a potentially major conflict of interest.

b. Rationale. The National Health Planning and Resources Development Act of 1974 currently permits designation as health systems agencies of not-for-profit corporations, public regional planning bodies or units of local government. Entities which are or operate educational institutions are prohibited from being so designated.

Many units of local government are major providers or purchasers of health care, frequently operating municipal or county hospitals or being charged with responsibility for administering and funding Medicaid or welfare programs under which health services are provided to segments of the population. If such government agencies should be appointed as health systems agencies or be allowed to control health systems agencies, a serious conflict between their interest as planners and their interest as purchasers of health care would result. Clear indication is provided in the statute that Congress did not intend this result; a multitude of safeguards are provided to ensure that health systems agencies would not be dominated by provider or purchaser interests.

American Hospital Association proposes that the statute be amended to prohibit local government agencies and private organizations that are major purchasers or providers of health care from being designated as health systems agencies. This will prevent the possibility that decisions about resource allocations will be made by those with vested interest in the outcomes.

c. Legislative Language. The following legislative language is proposed:

"Sec. 1512.

"(b)(1) Legal Structure.--A health systems agency for a health service area shall be --

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or
public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State Law (in effect before the date of enactment of this subsection) to carry out health planning and review functions such as those described in Section 1513, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution, nor may a health systems agency be a substantial purchaser or provider of health care nor control or operate an entity which is a substantial purchaser or provider of health care.
22. Coordination between HSAs and Health Care Institutions.
Section 1513

a. Policy Position. American Hospital Association supports amendments to the National Health Planning and Resources Development Act which will encourage coordination between the internal planning efforts of health care institutions and the areawide comprehensive health planning conducted by health systems agencies, with particular emphasis on development of alternate modes of health care delivery.

b. Rationale. Experience has demonstrated that effective health planning requires extensive cooperation between the public planning agencies and the institutions whose future existence and activities are being planned. National health policy should encourage both agencies and institutions to recognize that planning is the exclusive responsibility of neither. Results for both are often directly proportional to the degree of such cooperation. Health care institutions can benefit substantially from an effective regulatory planning process because they can base their individual expectations on what will occur on a system wide basis. Then, as institutional staffs become better able to plan and manage their internal operations, the HSAs will be freed of detailed project planning that institutions can perform more efficiently and will be able to devote more time and attention to the broader and more complex issues of coordination of community resources.

Health care institutions frequently lack knowledge of planning regulations. Perhaps because of this, some hospital administrators and health professionals do not have a positive orientation towards planning. On the other hand, many health planners are well equipped with theoretical training and methods, but lack practical experience in the management and delivery of health care resources. The public, as well as both organizations, will receive material benefits from increasing cooperation between institutions and the development of health plans, even in instances in which their conclusions may differ.

Cooperative planning by institutions and HSAs is possibly the best way of encouraging development of alternative approaches to cost and quality effectiveness in delivery of health care services. Perceptions of health care services should not become so closely tied to the traditional structures and functions as to preclude opportunities for adaption to changing conditions and provision of needed community health services in new ways.

The HSA should determine what services and facilities are necessary to achieve the most effective and efficient levels and scope of health care for the health service area, within local resource limitations. The responsibility of any HSA, however, must stop short of determining how such services should be administered and how such facilities should be managed. Hospital managers, trustees and medical staffs are best able to evaluate the needs and capabilities of their institutions and assess actions for improving them. Regulations enforced by the HSA should provide freedom for the exercise of management prerogatives to attain planning objectives.
To achieve the foregoing objectives, the American Hospital Association supports amendments to the National Health Planning and Resources Development Act which will encourage cooperation between HSA's and health care institutions, especially in the development of alternative modes and methods of delivery of health services.

c. Legislative Language. The following is proposed legislative language to amend the statute in accordance with the above policy:

COORDINATION OF PUBLIC AND INSTITUTIONAL PLANNING
SECTION 1513

"(d) Each health systems agency shall coordinate its activities with--

"(1) each Professional Standards Review Organization (designated under Section 1152 of the Social Security Act),

"(2) entities referred to in paragraphs (1) and (2) of Section 204(a) of the Demonstration Cities and Metropolitan Development Act of 1966 and regional and local entities the views of which are required to be considered under regulations prescribed under Section 403 of the Intergovernmental Cooperation Act of 1968 to carry out Section 401(b) of such Act,

"(3) Other appropriate general or special purpose regional planning or administrative agencies, and

"(4) any other appropriate entity, including entities which provide institutional health services.

in the health system agency's health service area. The agency shall, as appropriate, secure data from them for use in the agency's planning and development activities, enter into agreements with them which will assure that actions taken by such entities which alter the area's health system will be taken in a manner which is consistent with the HSP and the AIP in effect for the area, and, to the extent practicable, provide technical assistance to such entities.

"(d) Nothing in this title shall be construed to authorize any Federal or State officer or employee or the officer or employee of any health systems agency to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."
Mr. Rogers. Thank you, Mr. McMahon, for a very helpful statement, and we will be pleased to receive your specific language suggestions which would carry out your thoughts.

There is a call to the floor for a vote. I think if members could vote and return quickly, it would probably be the best procedure to follow at this time.

We will recess for 10 minutes. We are sorry to have to interrupt. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. Rogers. The subcommittee will come to order, please.

We are delighted now to hear from Mr. Bromberg.

Your statement will be made a part of the record in full [see p. 993]. If you could highlight it for us, as Mr. McMahon just highlighted his, that would be helpful to the subcommittee.

STATEMENT OF MICHAEL D. BROMBERG

Mr. Bromberg. I will try to do that.

I am Michael D. Bromberg, executive director of the Federation of American Hospitals. Accompanying me today is Robert J. Samsel, president of the Federation and vice president for Management Services and Marketing, Community Psychiatric Centers, Inc., of Santa Ana, Calif.

The Federation represents the more than 1,000 investor-owned hospitals and our member hospital management companies now manage under contract approximately 200 additional hospitals including teaching, religious, community nonprofit and public institutions.

We have supported the Planning Act since its passage, that concept that called for a clear preference of determination of needs at the State and local level not in the Department of HEW.

We have not changed our position in support of Public Law 93–641 and we recommend a 3-year extension of the Health Planning Act notwithstanding efforts by the Department of HEW to strain its interpretation of the law to control and regulate every aspect of the planning process. The Chairman and members of the subcommittee deserve special credit for defending the original intent of Congress that Federal health planning guidelines not be allowed to override the health needs of local areas. We do remain concerned that Government, faced with budgetary pressures, will continue efforts to arbitrarily control costs without adequate consideration of the quality health resources required in individual State or communities.

In order to preserve the bottom-up development of appropriate health plans based on local requirements, we urge amendments to Public Law 93–641 designed to clarify the scope of national guidelines on health resources and utilization. We recommend specifically the deletion of the requirement in section 1513(b)(2) of the act that health systems plans "be consistent with" the national guidelines, retaining the requirement that HSA's "take into account" those national guidelines.
The process for determining needed local health resources established by Public Law 93-641 must be given a reasonable opportunity for success and that requires Federal assistance, but without bureaucratic roadblocks. HSA's are still in the development state and consequently they are particularly vulnerable to Federal pressures and proposals for substantial expansion of their responsibilities. We urge amendments to Public Law 93-641 which will help HSA's meet the responsibilities already assigned to them in a fair and equitable process and we caution against expansion of their duties or illusions about unlimited cost savings without sacrificing quality of health care.

We advocate strengthening the capability of the local health system agencies by assuring that full financial support is provided by federally appropriated funds, as authorized in the law. This would permit the agency to attract experienced, qualified, and professionally trained staff personnel, able to understand the economic, financial, and administrative complexities of providing health services and institutional health care within the availability of health manpower and health facilities resources.

We support a 3-year extension of the Health Planning Act and offer the following comments on the proposed Health Planning Act Amendments of 1978, contained in H.R. 10460.

We endorse those provisions of section 209 which require inclusion on HSA governing bodies of elected officials and others broadly representative of the area. We urge expansion of this section to require inclusion of hospital representatives broadly representative of institutions in the area. The expertise of those knowledgeable in hospital administration is a necessary resource for governing board representation on a body charged with major responsibilities for making decisions on appropriate capital expenditures by hospitals. Hospital representation on an HSA executive committee should also be required.

We endorse section 215 which adds to the list of expertise which must be present on an HSA staff in financial and economic analysis. Health economists are needed by HSA's to properly assess projected population, industry, demographic, and economic trends and to interpret and translate the dynamics of change into impact on existing and future health services and facilities.

HSA staff should also have experience in hospital fiscal matters including reimbursement and budget issues.

It is imperative that the certificate-of-need responsibilities of State agencies and HSA's be met with continuing regard for due process of law. We urge the subcommittee to clarify the availability of judicial review following an adverse decision by the State agency.

The expansion of certificate-of-need coverage under section 218 to major medical equipment, regardless of location, raises several questions ranging from the degree of government intervention in the private practice of medicine to competitive advantages granted to certain types of providers.

On page 9 we try to make the point that where the process does not cover a particular class of providers, whether a physician's
office, HMO, or anyone else, the resources required and controlled by exempt providers not be counted in the determination of institution needs. We support the Chairman’s approach to treat HMO’s and physicians offices alike.

We also strongly urge the subcommittee to amend H.R. 10460 to specifically require Federal hospitals to comply with the same certificate-of-need requirements applicable to non-Federal providers.

We are concerned with section 1527(a)(3), which directs that a certificate of need be withdrawn if it is determined on an annual review that adequate progress has not been made. “Adequate progress” is a vague term which should be changed to reflect “good faith efforts to commence or continue the authorized project.” Progress can be blocked by Government, a striking construction union, or by others over whom the recipient of a certificate has no control.

On page 11 we endorse the definition of capital expenditure in section 218 and specifically the exclusion of simple acquisitions which do not involve changes in services or the number of hospital beds. The purpose of certificate of need laws is to approve new construction or the acquisition of new equipment and not to hinder the transfer of property rights. This change will also facilitate mergers, shared services, and the growth of multifacility systems.

We oppose section 218(b)(4) which changes the maximum review period for certificate-of-need applications from 90 days to 1 year. We support the consideration of competing applications at the same time, but see no justification for a 1-year delay in the decisionmaking process. In effect, this amendment encourages a 1-year moratorium on capital which could adversely impact on quality of care and increase costs by delaying projects to a period of higher inflation.

On page 12 we discuss appropriateness review.

Section 219(b) requires each State to have in place within 4 years a program which in effect decertifies inappropriate services. This directive begs the complex legal and economic issues involved in terminating health services or closing health facilities. We believe that any decertification program should be voluntary and carefully tested on a limited basis. When a facility or service is voluntarily decertified, it should receive payment equal to the fair value of the property to recognize debt and equity. Assurances should also be made to provide for employees who lose their jobs and to provide access to comparable care for displaced patients.

While we support experimentation with voluntary decertification, we also believe that the potential cost savings from hospital bed reduction have been grossly exaggerated. A well-managed institution will not incur substantial costs for maintaining empty beds beyond the interest payments and amortization of the debt.

A major reason for the high cost of maintaining some empty beds has been the cost reimbursement system which provides no incentive for efficient management of the personnel and other viable costs which should not be incurred for most empty beds.

For these reasons, the closing of some beds within a hospital will save little or no money; however, the closing or conversion of an entire institution can have a significant impact. We would recom-
mend that any experiment in voluntary decertification assign a priority to the closing or conversion of entire hospitals, rather than partial closings and that cost savings in such experiments be carefully analyzed before a more comprehensive decertification program is undertaken.

In addition to our comments on H.R. 10460, we offer the following suggestions for strengthening the planning process:

First, HSA's should be required to solicit competitive applications for needed services, equipment, and facilities in order to stimulate competition and lower costs.

Second, certificate-of-need agencies should be required to select the most cost effective of acceptable applications for needed services, equipment, and facilities.

Third, the definition of capital expenditures in section 1122 of Public Law 92–603 for medicare purposes and the definition for certificate of need under Public Law 93–641 should be consistent. We urge the Congress to raise the $100,000 threshold in section 1122 to $150,000, making it consistent with the Health Planning Act. In addition, we recommend that the dollar threshold be adjusted annually by an economic index reflecting general inflation factors.

Fourth, exempt replacement of equipment, plant maintenance, and capital expenditures mandated by law from the certificate-of-need process.

In conclusion we support the general approach of H.R. 10460 and urge the adoption of those amendments designed to assure fairness and objectivity in the certificate-of-need process, and improve funding and qualified staff, in order to strengthen the health planning process.

Thank you.

[Testimony resumes on p. 1010.]

[Mr. Bromberg's prepared statement and attachment follow:]
STATEMENT OF
MICHAEL D. BROMBERG, ESQ., EXECUTIVE DIRECTOR
AND
ROBERT J. SAMSEL, PRESIDENT
FEDERATION OF AMERICAN HOSPITALS
BEFORE THE
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT
OF THE
HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE
ON H. R. 10460
THE HEALTH PLANNING AND RESOURCES
DEVELOPMENT ACT OF 1978
FEBRUARY 2, 1978
Mr. Chairman and Members of the Sub-committee, I am Michael D. Bromberg, Executive Director of the Federation of American Hospitals. Accompanying me today is Robert J. Samsel, President of the Federation and Vice President for Management Services and Marketing, Community Psychiatric Centers, Inc. of Santa Ana, California.

The Federation represents the more than 1,000 investor-owned hospitals and our member hospital management companies now manage under contract approximately 200 additional hospitals including teaching, religious, community non-profit and public institutions.

Prior to and during the Congressional debate which lead to enactment of P. L. 93-641, the Federation endorsed the establishment of a network of health systems agencies and state certificate of need laws designed to assure sound health planning at the state and local levels. Our organization supported P. L. 93-641 in general at the time of its enactment and has supported the basic concept of that law since that time. That concept, as we understand it, embodied a clear preference for determination of need at the state and local levels, not in the Department of Health, Education, and Welfare.
We have not changed our position in support of P. L. 93-641 and we recommend a three year extension of the Health Planning Act notwithstanding efforts by the Department of HEW to strain its interpretation of the law to control and regulate every aspect of the planning process. The Chairman and Members of the Subcommittee deserve special credit for defending the original intent of Congress that federal health planning guidelines not be allowed to override the health needs of local areas. We remain concerned that government, faced with budgetary pressures, will continue efforts to arbitrarily control costs without adequate consideration of the quality health resources required in individual states or communities.

Development of Health Plans

In order to preserve the basic concept of bottom-up development of appropriate health plans based on local requirements, we urge amendments to P. L. 93-641 designed to clarify the scope of national guidelines on health resources and utilization. We recommend the deletion of the requirement in Section 1513(b)(2) of the Act that health systems plans "be consistent with" the national guidelines, retaining the requirement that HSAs "take into account" those national guidelines. In addition, we recommend adoption of H. R. 10251, sponsored by Congress- man Baucus, which establishes a procedure for Congressional
veto of national guidelines promulgated by the Secretary of HEW.

The Federation's primary concerns with the initial process in developing proposed national guidelines include:

(1) The "in the closet" method by which they were developed and the timing of their distribution by the Department: The law specifically requires the Secretary to "consult with, and solicit recommendations and comments from the health systems agencies . . . , state health planning and development agencies . . . , Statewide health coordinating councils . . . , associations and specialty societies, representing medical and other health care providers, and the National Council on Health Planning and Development . . . ."

The date the first proposed guidelines were published in the FEDERAL REGISTER, September 23, 1977, was coincidently the first meeting of the fully constituted National Health Planning Council, whose members were furnished copies of the proposals concurrent with distribution to the public. Failure of the Secretary to appoint the Council earlier and to consult with them certainly makes suspect the dedication of the Secretary to carry out the intent of Congress with respect to the development of such guidelines.
(2) The inflexibility of the proposed guidelines on local Health Systems Agencies: Health Systems Plans must "be consistent with" the guidelines "where they establish goals and set forth plans not in excess of the level set forth in the guidelines where that level is stated as a maximum, or not less than the level set forth in the guidelines where that level is stated as a minimum except where specific exceptions are provided in the guidelines." Failure to comply would result in disapproval of the Health System Plan and ultimate loss of status and operating funds for the health planning agency. An illustration of both the inflexibility of the proposed guidelines and the misuse of findings of research by HEW concerns the 4.0 beds per 1,000 requirement. The major study was that done by the Institute of Medicine, National Academy of Science, Washington, D. C., entitled "Controlling the Supply of Hospital Beds" and dated October 1976. The following is quoted from Page ix of the study:

"The committee recommends that a national health planning goal be established . . . to achieve an overall reduction of at least 10 percent in the ratio of short term hospital beds to the population within the next five years . . . this would mean a reduction from the current national average of approximately 4.4 non-federal short term general hospital beds per 1,000 population to a national average
of approximately 4.0 in five years
. . . the national goals should be applied
flexibly (emphasis added) to meet varying
conditions and circumstances in each state
and in the health service areas within the
state . . ."

(3) The use of specific quantitative guide-
lines and formulas: The Federation reiterates its
position that whenever specific numbers and formulas
are included in guidelines, that such standards should
be considered and adapted to the conditions and unique
needs of the local areas. To mandate conformance with-
out permitting local consideration and adaptation imposes
federal control, which as we interpret the statute and
understand the intent of Congress, was not intended.

For these reasons we urge modification of
P. L. 93-641 to require Health Systems Agencies to take
into account the national guidelines, but that Congress
repeal the requirement that health systems plans "be con-
sistent with" national guidelines.

The process for determining needed local health
resources established by P. L. 93-641 must be given a
reasonable opportunity for success and that requires
federal assistance, but without bureaucratic roadblocks.
HSAs are still in the developmental state and consequently
they are particularly vulnerable to federal pressures and
proposals for substantial expansion of their responsibil-
ities. We urge amendments to P. L. 93-641 which will
help HSAs meet the responsibilities already assigned to them in a fair and equitable process and we caution against expansion of their duties or illusions about unlimited cost savings without sacrificing quality of health care.

We advocate strengthening the capability of the local health system agencies by assuring that full financial support is provided by federally appropriated funds, as authorized in the law. This would permit the agency to attract experienced, qualified and professionally trained staff personnel, able to understand the economic, financial, and administrative complexities of providing health services and institutional health care within the availability of health manpower and health facilities resources.

We support a three year extension of the Health Planning Act and offer the following comments on the proposed Health Planning Act Amendments of 1978, contained in H. R. 10460.

Revision of National Guidelines

Section 201 of H. R. 10460 requires the Secretary to review the goals and standards established for health planning on an annual basis. We recommend that this requirement be changed to direct revision of the goals and standards at least once every two years. This would assure a more deliberative process with greater "prior consultation" with state and local planning
authorities, industry groups, and the National Council on Health Planning and Development.

We endorse the requirement that revised national goals and standards be based on plans developed at the state and area-wide levels.

Contributions to HSAs

We oppose Section 208 which would permit HSAs to accept financial support from insurers. Other provisions of H. R. 10460 take great pains to guard against conflicts of interest and we believe funding of HSAs should be accomplished without involving those who are part of the local decision making process. We would oppose provider contributions to HSAs for similar reasons.

Membership Requirements

We endorse those provisions of Section 209 which require inclusion on HSA governing bodies of elected officials and others broadly representative of the area. We urge expansion of this section to require inclusion of hospital representatives broadly representative of institutions in the area. The expertise of those knowledgeable in hospital administration is a necessary resource for governing board representation on a body charged with major responsibilities for making decisions on appropriate capital expenditures by hospitals. Hospital representation on an HSA executive committee should also be required.
Staff Expertise

We endorse Section 215 which adds to the list of expertise which must be present on an HSA staff expertise in financial and economic analysis. Health economists are needed by HSAs to properly assess projected population, industry, demographic, and economic trends and to interpret and translate the dynamics of change into impact on existing and future health services and facilities.

HSA staff should also have experience in hospital fiscal matters including reimbursement and budget issues.

Certificate of Need Programs

It is imperative that the certificate of need responsibilities of state agencies and HSAs be met with continuing regard for due process of law. We urge the Subcommittee to clarify the availability of judicial review following an adverse decision by the State Agency.

Expansion of Certificate of Need

The expansion of certificate of need coverage under Section 218 to major medical equipment, regardless of location, raises several questions ranging from the degree of government intervention in the private practice of medicine to competitive advantages granted to certain types of providers.
The aspect of this debate which has the greatest impact upon our hospitals is the manner in which certificate of need agencies define existing resources. If a particular piece of expensive equipment is located in a physician's office or within an HMO ambulatory care facility, but is not located in any hospital in the community, will an institution's application for a certificate of need be judged by existing institutional resources or by existing resources of any type regardless of location? Hospital patients should not be denied a needed service within the institution on the grounds that an HMO, to which they do not belong, or a doctor, who is not their personal physician, has that particular service or technology.

If the certificate of need process does not cover a particular class of provider, then resources acquired and controlled by those exempt providers should not be counted in the determination of institutional needs.

In addition, while we have supported the federal HMO Acts and continue to favor HMO development as part of a competitive pluralistic system of delivering health care, we do not believe that favored treatment in the certificate of need process is necessary or desirable. The conflict of interest provisions of H. R. 10460, which we endorse, should be adequate to
disqualify competitors from voting on HMO applications for capital expenditure approval.

We also strongly urge the Subcommittee to amend H. R. 10460 to specifically require federal hospitals to comply with the same certificate of need requirements applicable to non-federal providers.

We are concerned with Section 1527(a)(3), which directs that a certificate of need be withdrawn if it is determined on an annual review that adequate progress has not been made. "Adequate progress" is a vague term which should be changed to reflect "good faith efforts to commence or continue the authorized project." Progress can be blocked by government, a striking construction union, or by others over whom the recipient of a certificate has no control.

We also urge deletion or modification of Section 1527(a)(4) which requires that a certificate of need shall specify the maximum amount of the capital expenditure which may be obligated. This requirement could have an adverse impact on investments where delays beyond control of the holder of a certificate and resulting inflation cause minor cost increases which in turn force further delays in applying for a new certificate.
Section 1527(a)(6) requires that decisions of the state certificate of need agency be consistent with the state health plan. We recommend more flexibility to assure that special needs of a local area are taken into account and can take precedence over predetermined state goals.

We endorse the definition of capital expenditure in Section 218 and specifically the exclusion of simple acquisitions which do not involve changes in services or the number of hospital beds. The purpose of certificate of need laws is to approve new construction or the acquisition of new equipment and not to hinder the transfer of property rights. This change will also facilitate mergers, shared services, and the growth of multi-facility systems.

We oppose Section 218(b)(4) which changes the maximum review period for certificate of need applications from 90 days to one year. We support the consideration of competing applications at the same time, but see no justification for a one year delay in the decision making process. In effect, this amendment encourages a one year moratorium on capital which could adversely impact on quality of care and increase costs by delaying projects to a period of higher inflation.

Section 218(b)(6) requires that the efficiency and appropriateness of existing services and facilities be considered in the review process. We are concerned
that this criteria not be interpreted to deprive consumers of access to modern facilities or needed services as a punishment against existing substandard, antiquated facilities in the area which do not plan to upgrade plant or services. In addition, we urge the Subcommittee to specify that the burden of analyzing the efficiency and appropriateness of existing services and facilities rests with the HSA staff and not with the applicant.

**Appropriateness Review**

Section 219(b) requires each state to have in place within four years a program which in effect decertifies inappropriate services. This directive begs the complex legal and economic issues involved in terminating health services or closing health facilities. We believe that any decertification program should be voluntary and carefully tested on a limited basis. When a facility or service is voluntarily decertified, it should receive payment equal to the fair value of the property to recognize debt and equity. Assurances should also be made to provide for employees who lose their jobs and to provide access to comparable care for displaced patients.

While we support experimentation with voluntary decertification, we also believe that the potential cost savings from hospital bed reduction have been
grossly exaggerated. A well managed institution will not incur substantial costs for maintaining empty beds beyond the interest payments and amortization of the debt.

A major reason for the high cost of maintaining some empty beds has been the cost reimbursement system which provides no incentive for efficient management of the personnel and other variable costs which should not be incurred for most empty beds.

For these reasons, the closing of some beds within a hospital will save little or no money; however, the closing or conversion of an entire institution can have a significant impact. We would recommend that any experiment in voluntary decertification assign a priority to the closing or conversion of entire hospitals, rather than partial closings and that cost savings in such experiments be carefully analyzed before a more comprehensive decertification program is undertaken.

In addition to our comments on H. R. 10460, we offer the following suggestions for strengthening the planning process:

(1) HSAs should be required to solicit competitive applications for needed services, equipment, and facilities in order to stimulate competition and lower costs.
(2) Certificate of need agencies should be required to select the most cost effective of acceptable applications for needed services, equipment, and facilities.

(3) The definition of capital expenditures in Section 1122 of P. L. 92-603 for Medicare purposes and the definition for certificate of need under P. L. 93-641 should be consistent. We urge the Congress to raise the $100,000 threshold in Section 1122 to $150,000 making it consistent with the Health Planning Act. In addition, we recommend that the dollar threshold be adjusted annually by an economic index reflecting general inflation factors.

(4) Exempt replacement of equipment, plant maintenance, and capital expenditures mandated by law from the certificate of need process.

Conclusion

We support the general approach of H. R. 10460 and urge the adoption of those amendments designed to assure fairness and objectivity in the certificate of need process, and improve funding and qualified staff, in order to strengthen the health planning process.
SUMMARY OF RECOMMENDATIONS

BY

FEDERATION OF AMERICAN HOSPITALS

ON H. R. 10460

THE HEALTH PLANNING AND RESOURCES

DEVELOPMENT ACT OF 1978

FEBRUARY 2, 1978

(1) We recommend a three year extension of P. L. 93-641.

(2) We urge that HSAs be required to take into account the national health guidelines, but that Congress repeal the requirement that health systems plans "be consistent with" national guidelines.

(3) We endorse the requirement that revised national goals and standards be based on plans developed at the state and area-wide levels, but we recommend that revision be required every two years, not annually to assure greater "prior consultation" with interested groups.

(4) We oppose contributions to HSAs from any organizations with financial interest in the planning process, including insurers and providers.

(5) We support the requirement that elected officials and others broadly representative of the area be included on HSA governing bodies and we urge expansion of this requirement to include hospital representatives.

(6) We endorse the requirement that HSA staff have expertise in financial and economic analysis.

(7) We urge inclusion of specific provisions for judicial review from decisions denying certificate of need.

(8) If the certificate of need process does not cover a particular class of provider, then resources acquired and controlled by those exempt providers should not be counted in the determination of institutional needs.
(9) We recommend flexibility in the proposed requirement that certificate of need decisions be consistent with the state health plan to assure that special needs of a local area take precedence over predetermined state goals.

(10) We endorse the exclusion of simple acquisition from the certificate of need process where they do not involve changes in beds or services.

(11) We oppose the proposed change in maximum review period for certificate of need application from 90 days to one year, but support a requirement the competing applications be considered at the same time.

(12) We urge that federal hospitals be required to comply with certificate of need laws.

(13) We support experimentation with voluntary decertification of unneeded facilities and services even though we believe potential cost savings from bed reductions have been grossly exaggerated.

(14) We recommend additional amendments to require HSAs to solicit competitive applications for needed services and facilities with selection of the most cost effective proposal, and exemptions for replacement of equipment.
Mr. Rogers. Thank you for a concise and helpful statement.
Mr. Preyer.
Mr. Preyer. Thank you, Mr. Chairman.
I was, on a relatively minor point, I suppose, interested in Mr. McMahon's suggestion about Federal preemption of these multiple codes. I find hospitals in my area are continually upgrading through from local codes which have been more of a cost burden on them than any Federal regulations, I think. The idea of some uniform standards on that would seem to me to make a lot of sense.
I certainly appreciate your efforts to move more toward voluntary efforts and more flexibility in the local community. It is a question of trying to find the right sort of balance here, however. Everyone, I think, is in favor of controlling costs, but at the local level; as soon as you start restricting care in any way as a part of controlling costs, you stir up a political firestorm. So I think our standards have to be tough enough to put a little iron in the local community, or protect the local officials from too much political pressure if we want to get the job done on things like decertification. If a good-faith effort is made, and so forth, rather than, you know, saying "Do it."
I think it is a question of, will it work in a local community to rely on good-faith efforts?
Do you think they can withstand the political pressures in local communities if we make everything too voluntary?
Mr. McMahon. Yes, I certainly do. We begin, as I noted in the testimony, to go in the other way. Suppose it is mandatory, suppose a health system agency of 30, 40, 50 people say this institution has to close or reduce the service or something else. All of a sudden, because of that line, you put the organized medical staff, the employees of the hospital, and the entire patient load in a solid position of opposition whereas, if things move along—it is true they will be slower—but if things move slower to figure out ways, when an institution or service is underutilized, there is some recognition that something has to be done; but the physicians have to have a place to practice, the employees need a place to work, and the patients have to have a place to go for care.
Our whole thrust is built on the principle that education about the utilization system, plus incentives to encourage activity, will bring about an atmosphere in which things move voluntarily whereas the confrontational situation is likely to solidify the status quo.
Mr. Rogers. Will the gentleman yield at this point?
Mr. Preyer. Yes, of course.
Mr. Rogers. Dr. Carter is going to have to leave and I would like him to question before he leaves.
Mr. Carter. Thank you, Mr. Chairman.
You are very strong in your belief that hospital administrators should have a prominent part in the HSA's; is that correct?
Mr. McMahon. Yes, sir.
Mr. Carter. What percentage?
Mr. McMahon. A minimum of one.
Mr. Carter. One percent?
Mr. McMAHON. A minimum of one individual, that there should be at least one person from hospital administration or hospital management because the HSA needs to have somebody that can explain the whys and wherefores. That is why we have encouraged the inclusion of a manager or administrator. There may be a trustee or somebody that might be helpful in other areas, but they don’t understand the administration.

Mr. CARTER. How many nurses?
Mr. McMAHON. I think that can be left to the local determination. I think because of the importance of the hospital—
Mr. CARTER. Do the nurses think that?
Mr. McMAHON. No; they do not.
Mr. CARTER. What about dentists, what about their representation, oral surgeons, particularly?
Mr. McMAHON. That is another problem. I would not mandate that because of the difference in the practice of dentistry, particularly in the smaller areas and trying to deal with that kind of issue in this context—
Mr. CARTER. Even in the smallest hospital we have to have some dentists to help us, practice ancillary surgery, and so on; and they feel deeply about it, too.
Mr. McMAHON. I am sure they do.
Mr. CARTER. What about insurers?
Mr. McMAHON. They should be consumers.
Mr. CARTER. All of these are consumers, are they not? Are you considered as a consumer at the present time?
Mr. McMAHON. No, sir, I would not be. I would be a provider.
Mr. CARTER. You are a provider, insurers are not considered as consumers, they are providers?
Mr. McMAHON. Yes.
Mr. CARTER. Everyone I have mentioned is a provider?
Mr. McMAHON. The insurance people ought to be consumers.
Mr. CARTER. You want to increase the percentage of insurers? Did you make that statement, Mr. Bromberg?
Mr. BROMBERG. I wanted to increase the number of public-elected officials as part of the present consumers.
Mr. CARTER. Will we diminish the number of hospital administrators, nurses, dentists, physicians, to accommodate the public officials?
Mr. BROMBERG. Let me make one point. The long list you gave us is a worthy list.
Mr. CARTER. I don’t want a dissertation.
Mr. BROMBERG. The only component of the list you gave which is required to obtain a certificate to open, close, or purchase equipment is a hospital. For hospital management to be absent we think for that reason is a more obvious absence than any other profession.
Mr. CARTER. Public officials, what percent of either group should they compose?
Mr. BROMBERG. We would recommend up to 25 percent of consumers.
Mr. CARTER. Twenty-five percent of public officials. Again, would they be consumers or providers?
Mr. Bromberg. It would seem to me most should be consumers.

Mr. Carter. You are diminishing the real providers. They are getting less and less until you have no dentists, doctors, or nurses, or surgeons in your group. They will all be publicly elected officials and hospital administrators and other consumers.

Thank you, gentlemen. I have to go.

Mr. McMahon. Could I add one comment for the record? This is a matter about which there is a great deal of confusion. My statement would go to some of the ways I think you might go. We spoke to the advisability of having hospital management because of the impact of certificate of need.

Obviously the committee has to look at other kinds of providers and consumers and we think that insurers, because of their interest, are more consumer oriented. I would say we have seen, as Mr. Preyer knows, and because of my own background, a strong predilection for involvement of State and local officials in this. The committee might want to consider a separate category of State and local government officials, rather than diminishing one group or the other.

We have not given it consideration but, in my personal opinion, I would not see any problem with setting up a separate governmental group. They are represented today and must be.

Mr. Rogers. Mr. Preyer, go ahead.

Mr. Preyer. I don’t have another question, but I want to thank you for your always useful suggestions and say that it seems to me the hospitals in my State have become much more cost conscious in the past few months. I think they have always done a pretty good job, but I give you gentlemen credit for making them take unusual measures lately and I hope that is going on all over the country.

Mr. Bromberg. If I could add for the record, we should thank you, too, since you served on a commission that recommended that we take this effort.

Mr. Rogers. Mr. Walgren.

Mr. Walgren. Just briefly, I am so new in this that I don’t know what the past job the hospitals have been doing, how good a job that has been. From Mr. Bromberg’s statement it would seem that some of the excess cost that should be able to be squeezed out apparently does come from a lack of sufficient management personnel and when costs are not sufficiently reimbursed. Do you have a suggestion on how to get at that excess cost?

Mr. Bromberg. We have now, I believe, for 11 years, appeared before the U.S. Congress and recommended that cost reimbursement under medicaid and medicare be phased out of existence. We continue to recommend it and some kind of target situation be established. We supported a bill cosponsored by Congressman Rogers and Senator Talmadge which would reward hospitals who come in below their peer-type hospitals and penalize those coming in above it.

We continue to recommend that just as we would continue to recommend, that insurance coverage be revised to treat outpatients and inpatients alike. We think a number of things like that could be done to turn the incentive around.

Congressman Preyer mentioned it before and Mr. McMahon did. We think the hospitals’ managers need that little incentive to squeeze
some costs out. We don’t think it is as much as the administration does. However, we think to reward that effort would be helpful.

Mr. McMahon. In direct response to that I think the attention of hospital management is changing. The attention in the sixties was on ways to provide more and better care for patients—expansionist tendencies, if you like—and that was the key thing attention was focused on. Now there is a vastly different attention span because of the message from the payers of care, from business, from labor, from the public at large about the concern of hospital costs. That is why there have been in evidence in the last year or two a reduction in the rates of increases and why there is sympathy and support for the voluntary effort now going on, recognizing, as we testified before, that unlike a single yardstick applied to each institution, we need to accept the goal of the reduction in the rate of increase but tailor it institution by institution to what can be done in each institution, incentives in some cases but attention to the individual institutional problem which will work much better than an across-the-board yardstick.

A great advantage to the voluntary effort, like voluntary efforts I mentioned in response to the chairman’s question about certificate-of-need, the encouragement and incentivizing of institutions will get the job done much better in a more fair and equitable way with better attention to patient care than an across-the-board yardstick.

Mr. Walgren. I take it you target medicare and medicaid reimbursements to explain hospital cost escalation. Isn’t the problem really that all medical costs are seen as insured expenses? And that the payment for these costs is not seen as a real expense because it is handled by a third party?

Mr. Bromberg. Directly on point, Mr. Walgren, and we have said the reason why the Commission, the AMA’s Commission on cost of medical care and in which Mr. Preyer made such a useful contribution, was to recognize and do something about the problem that exists, the problem of a rate of increase in health care costs and hospital costs that exceed the rise in the gross national product. We need a variety of measures. We need greater involvement in the economic dimensions of care by and the education of physicians. We need to strengthen physician review and audit. We need, on the institutional side, greater attention to efficiency as well as to the efficacy of procedures underway.

Finally, in many of the recommendations of that report we can see a need to alert the public to what its demands are doing to push up cost of care, and call for better attention to care of each individual by himself or herself. A better understanding of what to do when one is sick, injured or does not feel well is absolutely necessary to do something about the demand that itself is a part of the reason for increased costs and also inflation.

On educating the public not to ask for more and more. I am convinced the physicians are the key.

They order the tests, admit and discharge, and I believe the physician is most influenced by the patient. A lot of what the doctor does he might do differently if the patient incentives were different. If outpatients and inpatients were covered equally, the patient
would not ask to be in the hospital so it is all paid for. The patient
would not reject office treatment if it was paid for, or at best 80
percent. We are all to blame, but it is the same Government and
Cabinet officers we have today as 12 or 14 years ago when medicare
passed. People were saying we want more access and more and
better services. Now when the budget is in and it is tough, instead
of changing the underlying program on cost reimbursement and
insurance, they just want to put a cap on and keep it the way it is.
The same problem is shared by all of us.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. Rogers. I notice you say that the cost reimbursement system
really provides no incentive for efficient management, Mr. Bromberg.
What do you suggest?

Mr. BROMBERG. I would suggest immediate passage of the Tal-
madge-Rogers bill to correct it for at least the medicare and med-
icaid, which is about 40 to 50 percent of the business of most hos-
pitals. I would suggest the voluntary effort and, if we ever consider
national health, we abolish it from being used by private insurance
companies.

Blue Cross has about 26 percent now of prospective rates, all
different kinds. We feel the most likely to succeed are those under
your bill and the Talmadge bill, hospitals of similar geographic
areas, similar services, find the average cost of procedure and say,
"That is the target rate. Those significantly above we won't pay."
If a patient was going to a hospital like that, the patient should
bear the additional cost.

Mr. Rogers. I was pleased to see both organizations are support-
ing the extension of the bill. I notice you have some suggestions for
change and making clear that guidelines are guidelines and not
directives. I think this committee has pretty well gotten that com-
mitment from the Secretary and the Department.

Mr. McMAHON. We hope you will look at the language change we
have suggested to make sure that commitment is permanent and
survives various encumbrants.

Mr. Rogers. We will look at that.

Also, the review procedures, you would consolidate requirements
for review procedures, I believe, McMahon? That is on page 6,
Pub. L. 93–641 requirements for review procedures in section 1532.

Mr. McMAHON. Yes.

Mr. Rogers. You think that would be an essential?

Mr. McMAHON. Yes, we do.

Dr. GEHRIG. The proposed project should be acted on so a re-
sponse is made and, if no response is made, the project should be
approved in the 90-day period. There has been a suggestion that not
saying anything means it is approved, this is totally unrealistic.

Mr. McMAHON. In our testimony we talked first about the recom-
mandations for amendment to the existing law. We have not com-
pletely meshed those original studies we made with your new bill.
We will be doing so and, as I requested in one specific area, we
would like permission to submit further recommendations if we see
ways we can tie some of these amendments directly to the changes
you made.
Mr. Rogers. Also, you might give us your ideas on the definition which you asked us to redefine of “indirect provider” serving on the board. What specific language or what intent would you have set forth in the definition of indirect provider?

Mr. McMahon. We set that forth at the bottom of page 7 of the regular testimony. We have it in the attachment. I will ask Mr. Earle to direct himself to that question.

Mr. Earle. Most of our proposals are technical in nature to try to clean up the definitions in the law. There are specific amendments, for example, there are those who under the current law would be classified as an indirect provider who should fall under the consumer category. We are attempting to clear that up. We are also recommending those people, the insurance people, be reclassified as consumers rather than on the indirect provider side. A few other amendments, like that to try to clarify this particular provision.

Mr. Rogers. What about members of the immediate family?

Mr. Earle. That is part of our definition?

Mr. Rogers. I presume you would classify as providers people in the voluntary sector who are volunteers but, if they are professional people in the volunteer sector, how would you classify those?

Mr. Earle. They would be providers. If it is less direct connection then they ought to be classified in the consumer category.

Mr. Rogers. You think the Federal code should develop a single code and set of standards for physical requirements which would apply to all Federal programs and all State and local governments should be encouraged to adhere to this?

Mr. Earle. Yes.

Mr. Rogers. What are you thinking of starting with to simplify the code?

Mr. McMahon. No, Mr. Chairman, we are starting with the problem of duplication and conflict. The situation that is brought to our attention over and over is where the local building code says one thing and OSHA says something different. It is the content of the code rather than the detail that causes the problem. We don’t know where else to turn but to the Federal Government. We recognize that some States and localities will insist that peculiar problems of their own require special attention. We mentioned that in the testimony. We think we must start with a Federal set of standards, Federal involvement in the code and standards and regulations that are developed in order that we can avoid the conflict and focus in on that which is necessary rather than that which is desired, particularly in a cost containment era.

Mr. Rogers. I notice you support uniform reporting. Do you support uniform accounting?

Mr. McMahon. No, sir; and let me make clear for a minute that we think that accounting must have at the outset a management dimension. The real purpose of accounting is to enable managers to manage the institution. We have absolutely no problem with the desirability of uniform reporting and have worked out, as you recall, in connection with H.R. 3, we have worked out a modus vivendi with HEW on the way we are proceeding. We are in discussion
with them. The Planning Act has a little different provision than H.R. 3. We would like the two to be brought into agreement.

Mr. Rogers. What assurance do we have the reporting reports will have similar and identical facts and figures unless we have uniform accounting?

Mr. McMahon. HEW has proceeded to develop a mechanism by which that appears in the entries in the accounts of the institution set up to provide it with managerial information will go through a defined set of accounts into the reports. The thing is that this can be done periodically when a report is necessary rather than forcing the institution into a uniform accounting system which suits the purpose of the Federal Government but not necessarily the purposes of institutional management.

Mr. Samsel. The difference is in definition. As long as the amounts we are trying to account for are defined in the same way and going to the same account, there is no need to change the name of the particular account as long as it holds what we are looking for as a cost item. The problem of trying to set up a uniform chart of accounts for all managers everywhere means we all have to start speaking the same language, such as Florida, California, Washington, and so on, and we all have a different financial language. It works a great hardship on the financial manager if he has to change his system to agree with somebody else's. This is a national program and we believe the definition of what is included in an account is what is important, not necessarily the accounting system.

Mr. Rogers. I believe most of the groups in your federation who own more than one hospital probably have uniform accounting within their system, do they not?

Mr. Samsel. We have uniform reporting, Mr. Chairman.

Mr. Rogers. You don't have uniform accounting?

Mr. Samsel. Not necessarily. There is always a line—

Mr. Rogers. Everyone I have asked before has told me that where they may have a hundred hospitals in their system—they have uniform accounting.

Mr. Bromberg. Many have uniform accounting. Most have an internal uniform accounting system. What they call it is a uniform accounting system which is "management oriented" rather than cost oriented. They would need two accounting systems if Government had its way.

Mr. Rogers. Maybe we would take the same one. If it is all the same verbiage.

Mr. Samsel. It would work in one system.

Mr. Rogers. There has been a uniform accounting system recommended, has there not?

Mr. McMahon. Yes; where the managerial requirements may be met.

Mr. Rogers. I wanted to get that on the record, within your system you do it and you recommend it to your members.

Mr. Samsel. Again, those are guidelines.

Mr. Rogers. I understand. We all know what guidelines are.

Mr. McMahon. We thought we knew what guidelines were.

Dr. Gehrig. In the discussion, and as we understand your bottom line, it is to obtain uniform reporting.
Mr. Rogers. Just so we understand.

Dr. Gehrig. The Department agrees that can be obtained without the straightjacket of uniform accounting.

Mr. Bromberg. Since it is our membership that has the internal system, we don't recommend it to the members.

Mr. Rogers. They already have it; that is correct.

Thank you for your testimony. It has been most helpful. We appreciate that. You have come in in a constructive way to help Congress in fashioning legislation that can be most helpful to the nation and its future health needs.

Thank you.

The next witnesses will be a panel of health maintenance organization representatives: Mr. James A. Lane, vice president of the Kaiser Foundation Health Plans, Inc., Kaiser Foundation Hospitals in California, accompanied by Dr. Frank Newman, vice president of the Kaiser Foundation Health Plans, Inc.; and Mr. Lewis J. Segadelli, executive director, Group Health Association, Inc., in Washington, D.C.

We welcome you gentlemen to the committee. Your statements will be made a part of the record in full, without objection, and you may proceed. It would be helpful to the committee if you could highlight the points you think the committee should direct its attention to.

STATEMENTS OF JAMES A. LANE, VICE PRESIDENT AND COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC., ACCOMPANIED BY H. FRANK NEWMAN, M.D., VICE PRESIDENT; AND LOUIS J. SEGADELLI, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION, INC.

Mr. Lane. Thank you.

I am Jim Lane. I will address the impacts on HMO's and the serious problem it makes for HMO's in this area and there will continue to be problems unless it is amended.

The conflict is because there is conflict in the basic policy of the Government.

In 1972 the Federal Government through H.R. 1, section 1122 of that provision and through the Planning Act has embargoed on a course of restricting capital resource development. On the other hand, since 1973 the Federal Government through the Health Maintenance Act and amendments has encouraged the expansion and development of health maintenance organizations. Those two policies are in direct conflict because the Congress in both 1972 and 1974 chose to cover all activities of health maintenance organizations under the provisions of 1122 and the certificate-of-need requirements in the Planning Act, whereas it only covered some of the activities of other providers that do not operate on a prepaid basis. This policy is grossly discriminatory. It is discriminatory because ambulatory facilities and HMO's require certain approval while the same physicians and insurance companies do not. It is secondly discriminatory because, whether it is intended to do so or not, it perpetuates the status quo. Certificate-of-need laws are inherently
discriminatory against the new entrants, new organizations and especially discriminatory against the innovative organizations.

Now, I have searched through the records and through the evidence presented to the Congress as it was deliberating over the question of including or drafting certificate-of-need requirements and I have found no evidence that there are too many HMO's in the country, too much ambulatory HMO capacity or too many HMO hospitals. There is no need in this country to control the development of health maintenance organizations. Therefore, it is our conclusion that health maintenance organizations should not be covered by certificate-of-need requirements under this law.

The only basis put forward is the basis of the quality of treatment; that is, if you are going to cover fee for service hospitals, you should cover HMO hospitals. We think this, although apparently a fair analysis fails because of what has gone on in the last 3 or 4 years and I would like to give some examples. The basic problem is the planning process is so preoccupied with fee for service hospitals and providers it totally ignores HMO's. Last summer a State medical facility issued guidelines, a 277 page document directing States how to establish facilities under this act. There was not a single mention of HMO's. They were totally ignored. The national guidelines were issued in 1974, not a single mention of health maintenance organizations. On the local level I have been examining plans by the HSA's for critical review and it is extremely difficult to get them to mention HMO's.

In Los Angeles they didn't even bother to put in the language required by the Federal regulations and State law until we brought it to their attention.

So, on the outside it appears equal treatment is being provided but it is not in fact being provided. We think the only solution is to exclude all HMO's from the certificate-of-need requirements of this act and from section 1122 and, in addition, there is one other thing that needs to be done; that is, to prohibit States from covering HMO's in their acts.

What happened is that after the public law was passed the States started the process of requiring the certificate-of-need laws. We opposed the inclusion of HMO's in that law because we are working with Congress to try to change that.

In 1979 that issue was before the Congress and the Senate in the HMO amendments eliminated HMO's from the certificate-of-need requirement. This body did not. In Congress it was resolved by leaving HMO's in the act. At that time Chairman Rogers said that that matter would be resolved in 1977 when 93-641 was up for review. It was not because it was up for a simply 1-year extension. Nevertheless, he promised to examine the issue and treat HMO's and fee for service providers the same. That is what is attempted to do in this act. Nevertheless, since then many States, for only one reason, not because they felt it necessary to cover HMO's because they were compelled by the Federal Government to do so, have covered HMO's under their acts. Others are considering doing so in their sessions going right now. They don't want to do so in Oregon and Hawaii. They don't want to do so in Ohio, or in California. They will do so only if compelled.
Once in, however, it will be extremely difficult for those HMO coverage provisions to get out. They will be opposed by certain vested interests within the States. We think in some States we will be able to persuade State legislatures they should be removed, but we are fearful of what will happen where little HMO's are just getting started and have no capability to affect State legislation in their area.

We think Congress has to address the issue and prohibit States from covering HMO's to the extent Congress decides they should not be covered under Federal law.

I suggest there will be considerable disagreement with our conclusion and would like to advise what you should do if you don't exclude HMO's. We concur in the provision that HMO ambulatory provisions should not be covered. There is considerable criteria covered when you examine the application. The need should be based on the existing or reasonable anticipation of new members of HMO's. That way the HMO's can plan for growth and development. This should be particularly true in ambulatory care and equipment, and in modernization and remodeling.

One of our biggest concerns is we will be prevented from keeping our facilities from being modernized, somebody will decide we should be prevented from spending our money to modernize our facilities. If hospitals of HMO's are to be covered, there is a serious problem. The reason usually given is HMO's should be able to use hospital facilities in the rest of the community. That is sometimes the case.

In Colorado we do use a community hospital. It has been very successful in its organization. That is not always the case. You can't always find the beds, you can't always find physicians associated with HMO's and admitted to the staff. You can't always find financial arrangements are adequate.

On page 7 we proposed some criteria to be used in determining whether HMO's can get hospital service in the communities or not. We feel if HMO's can't get hospital service in a community based on this criteria it should be allowed to construct its own hospitals.

Two other points. We feel that the health systems plan and the State health plan and the State medical facilities plan should be required specifically to deal with the development of HMO expansion. The States in the HSA should be required to deal with and address the question of how many and how much HMO capacity there should be.

The second issue, section 1527—this is not in my statement because I didn't have the bill at the time I prepared it—section 1527(a)(6) provides certificate-of-need decisions should be consistent with the health systems plan. That sounds fair.

The problem is that most health system plans won't address many of the projects for health nor certificates of need. For example, medical office buildings, the plans I have examined don't have any criteria for determining whether a medical office building in an HMO is needed, parking lots, clinical labs, leading of computers. We had to get a certificate of need to get a computer in California. Leasing
space, as we rent an office building for our health plan officers, we have to lease it. None of the plans has dealt with those issues.

We recommend you provide not that the application must be consistent with the plan but that it not be inconsistent with the plan, a substantial difference. If the plan is silent on the subject, you do not need to show consistency with it.

In conclusion, as I indicated before, there is a substantial conflict in Federal policy between resource control and between HMO expansion. We think that the conflict right now is in the direction of very seriously hampering HMO development in this country and, therefore, we strongly recommend it be resolved in favor of HMO development.

We will submit very soon proposed amendments which will accomplish this objective.

[Testimony resumes on p. 1037.]

[Mr. Lane's prepared statement and attachment follow:]
Statement Before the Subcommittee on Health and the Environment
of the Committee on Interstate and Foreign Commerce
United States House of Representatives

Submitted by Kaiser Foundation Health Plan, Inc.

February 2, 1978

Mr. Chairman and Members of the Committee, I am James A. Lane, Vice President and Counsel of Kaiser Foundation Health Plan.

The Kaiser-Permanente Medical Care Program

The Kaiser-Permanente Medical Care Program is comprised of Kaiser Foundation Health Plan, a nonprofit corporation, Kaiser Foundation Hospitals, a charitable and nonprofit corporation, and six independent Permanente Medical Groups. It is an economically self-sustaining health care system that provides prepaid health care services to more than 3.3 million members in California, Oregon, Washington, Hawaii, Ohio and Colorado. It is a systematically planned and organized approach to the provision of health care that arranges direct health care services for its members in 26 acute general hospitals and 72 outpatient facilities. The Program employees more than 28,000 non-physician personnel. Professional services are provided by more than 3,300 physicians associated with the independent Permanente Medical Groups.

The Kaiser-Permanente Program is the largest group practice prepayment program in the United States. It has succeeded and grown in the face of healthy competition from commercial health insurance, Blue Cross, Blue Shield, self-insured programs, and other HMOs,
despite the opposition of some segments of organized medicine. The Program has pioneered many features, such as comprehensive prepaid services, including prevention and early detection of disease, quality assurance based on peer review, and effective cost control, particularly with regard to expensive hospital services, that Congress has sought to encourage and expand.

Congress intended to encourage development and expansion of group practice prepayment programs when it enacted the Health Maintenance Act of 1973 and the HMO Amendments of 1976. This occurred because such organized health care systems have demonstrated their ability to provide a comprehensive range of prepaid health services to their members at a reasonable cost. They are at the forefront of innovation in health care delivery and have led in providing preventive health services and using health care resources efficiently. Furthermore, the success of group practice prepayment programs has resulted in innovative responses from traditional health care providers, such as development of Foundations for Medical Care and expansion of the prepaid benefits offered by competing health benefits carriers.

HMOs and P. L. 93-641

Therefore, it is ironic that as far as health maintenance organizations are concerned, P. L. 93-641 could be called the Anti-HMO Act of 1974. This is because the Act's required certificate of need program discriminates against and creates serious problems for HMOs in two ways.
First, HMOs are required to obtain certificates of need for their ambulatory and administrative facilities and equipment while fee-for-service providers are not.

Second, HMO hospitals (hospitals that provide 75 percent or more of their services to HMO members) are covered in the same manner as fee-for-service hospitals. Although this may appear to be a neutral posture toward HMOs, it is, in fact, discriminatory. Certificate of need laws perpetuate the status quo. They protect existing facilities from competition without regard to the need for such facilities, their quality or their cost effectiveness. Discrimination also occurs due to the bias against HMOs of some providers who serve on Health Systems Agency (HSA) boards.

Congress was concerned about this bias and the Act requires State Agencies and HSAs to consider the special needs and circumstances of HMOs for which assistance may be provided under title XIII of the Public Health Service Act (§1532(c)(8)). However, the Department of Health, Education and Welfare has failed to adopt adequate regulations to implement this provision despite clear instructions to do so in the Conference Report on the HMO Amendments of 1976 (pp. 36-37).

Therefore, we have concluded that the most appropriate action to insure that certificate of need programs do not impede development and expansion of HMOs is to exclude HMOs and their facilities, including their hospitals, from required certificate of need programs.

The exclusion also should provide that a state health facilities
planning program may not be approved by HEW if it requires certificates of need for HMOs or their facilities. This is necessary because some states have already included HMOs in their certificate of need programs pursuant to the requirements of P. L. 93-641, and it may be difficult to exclude HMOs from certificate of need laws in some states due to the opposition of those special interests which want to control or stop HMO development.

HMOs and their facilities should be excluded because:

1) There is no reason to impose external constraints upon the development of HMO resources. Unlike the fee-for-service system which certificate of need programs are designed to regulate, HMOs have inherent incentives which result in appropriate development of resources to meet the needs of existing members and reasonably anticipated new members. HMOs have no incentives to have unnecessary facilities or to provide unnecessary services.

2) Mature HMOs have demonstrated their capability to plan appropriately and new HMOs have shown that this capability can be replicated.

3) Hospital-based HMOs have grown at a rapid rate and should be encouraged to continue that growth without changing their essential method of operation. They should not be required to attempt to use unacceptable, inefficient or otherwise undesirable excess resources in the area. Although conceptually attractive, the use of such resources can fragment and distort an HMO's delivery system and can impair
the quality and availability of services to the members of HMOs.
HMOs have not been responsible for developing excess resources.
They should not be required to use inappropriate facilities and in-
crease the costs for their members.

4) The certificate of need process can cause unreasonable de-
lays and exhaust valuable managerial resources. Even though a
certificate of need is granted, it may be after a substantial struggle
and considerable delay. This is especially true where there is strong
anti-HMO bias.

5) Hospital-based HMOs combine appropriate hospital utilization
with increased physician efficiency and thus have lower total costs than
non-hospital based HMOs. Being hospital based enables an HMO to
develop needed resources in more appropriate ways. This model
should be encouraged, not artificially constrained by certificate of need
laws.

6) If an HMO is required to use excess resources in an area,
there is no guarantee that they will be available to HMO members as
long as they need them. One concern is that hospital based HMOs
will be denied permission to build based upon a short-term bed surplus
which will disappear because of population growth or an aging popu-
lation. The resulting shortage of beds will mean that the bed needs
of the HMO's members can no longer be met and it will have no alterna-
tive resources available and will not be able to construct necessary
beds within a time frame that will meet the needs of its members.
7) If a hospital-based HMO is allowed to develop its own hospital in an area where there are excess hospital beds, the cost to the total community will be lower in the long run than if the HMO is not allowed to expand. (See Exhibit I.)

We strongly support the exclusion of HMO hospitals from certificate of need requirements, but the Committee may feel differently; if so, we suggest the following guidelines in making decisions concerning HMOs and certificate of need programs:

1) HMO facilities, and equipment should not be covered unless fee-for-service facilities and equipment are covered. To do otherwise is discriminatory.

2) States should not be permitted to include any HMO facilities and equipment which are excluded from Federal certificate of need requirements. Otherwise, because many states have already included HMOs, elimination of the federal requirement may have no effect.

3) The public interest in fostering development of effective organized health care delivery systems requires that projects for HMO facilities and equipment should be judged on the needs of existing and reasonably anticipated new members of the HMO, not on the needs of the community in general. This is especially important for the modernization and replacement of existing HMO hospitals and other facilities. An HMO should not be denied approval to maintain or modernize its hospitals and other facilities simply because there are excess hospital facilities in the area. To do so, would result in disruption of existing
services to HMO members and fragmentation of effective health delivery systems.

4) If HMO hospitals are covered, an HMO should be allowed to build its own hospital unless the State Agency determines that hospital services are available to HMO members in a cost-effective manner which is consistent with the basic method of operation of the HMO. In making such a determination, the State Agency should be required to find that:

(a) The services are available in one hospital;

(b) The services are available on a long-term contractual basis commensurate with other long-term commitments of the HMO or five years, whichever is longer;

(c) Qualified physicians associated with the HMO will be granted full staff privileges at the hospital; and

(d) The services are available in a manner which is economically and clinically feasible for the HMO.

Anything less than this in the Act will leave HMOs at the mercy of regulation writers and the interpretations and biases of HSAs and State Agencies and will continue the discriminatory aspects of P.L. 93-641.

We recommend two additional changes. First, HSAs and State Agencies should be required to prepare specific plans for HMO development and expansion. Each health system plan and state health plan should contain an HMO element which describes existing HMOs, their membership, facilities and services and their plans for expansion. It should be the goal of each HSA and State Agency to develop enough HMO
capacity so that all persons in the area will have the option to voluntarily join an HMO. Otherwise the objectives of the HMO Act of 1973 can be subverted.

Second, §1513(e) should be amended so that HSAs are limited to review and comment authority over grants, contracts, loans and loan guarantees under the HMO Act, rather than review and approval authority. The implementation of the HMO Act has a high national priority. HSAs should not be permitted to thwart this priority by disapproving HMO development or expansion projects which HEW determines are in the national interest.

These changes P. L. 93-641 are essential to development of new HMOs and rapid expansion of existing HMOs. This is a stated goal of Congress and the Administration. It should not be frustrated by a planning act which is designed to impose rationality upon the fee-for-service delivery system. HMOs already plan rationally because they have internal incentives to do so.

Sound public policy requires that regulatory systems be carefully designed to address specific problems. They should not be applied to organizations which are not creating the problem or in a manner which inhibits organizations which have great potential to assist in solving the problem. Therefore, we conclude that the soundest approach is to exclude HMOs and their facilities and equipment from certificate of need programs and not permit states to cover them.
SELECTED USE OF COMPETITION
BY HEALTH SYSTEMS AGENCIES

FINAL REPORT

Submitted to:
Bureau of Health Planning and Resources Development
of Health Resources Administration, DHEW
Contract No. HEW-HRA-230-75-0071

December 1976

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Suite 400, Washington, D.C. 20036
This is especially the case where competition from HMOs and other health plans ensures that individual HMOs maintain close control over their expenditures. The possible exceptions would be where HMO competition does not exist or where external subsidies offset the effect of such expenditures on premiums. However, in general, there is little evidence that there is anything to be saved by implementing controls over HMO outpatient facility construction and equipment purchases, especially in light of the cost of implementing these controls and the risk of limiting the long-term useful effects of HMO competition.

c. HMO Hospital Construction. We found that several large HMOs have sought to build or purchase their own hospitals when their enrollments reached high levels. Hospital ownership appears to produce significant savings over the continued use of non-HMO facilities and allows HMOs to improve the quality of inpatient care to their members. In addition, hospital ownership ensures that beds are available when needed, that HMO physicians can obtain staff privileges and that HMOs do not indirectly subsidize other health plans. In order to evaluate the desirability of HMO construction of hospitals, we estimate the impact of HMO hospital construction on community costs. We assumed that an HMO’s acquisition of its own hospital produced net savings from all sources of 10 percent in average HMO costs. Although there is little evidence on the actual savings available from HMO hospital ownership alone, HMO administrators indicate that a ten percent savings seems attainable. This savings is consistent with the HMO cost comparisons cited in Chapter III. Using this assumption and our HMO cost model, we examined the annual community costs (savings) per
member under two cases: the first, where community beds are not needed; the second, where they are needed. In addition, we examined the impact of alternative HMO enrollments over the likely range of values where hospital construction might be effective. Table II-9 summarizes these results.

<table>
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<td>($ 3.25)</td>
<td>($ 5.10)</td>
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<tr>
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</table>

We found that where community beds are needed, HMO development and HMO hospital construction both produce substantial savings. HMO hospital ownership clearly enhances the savings made possible by encouraging HMO development. Where beds are not needed, HMO hospital ownership still produces community savings, but is less attractive than the continued use of existing hospitals. The best alternative in this situation is the purchase of an existing hospital by the HMO. Specifically, our analysis suggests that:
where additional community beds are needed, community costs can be reduced the most by permitting an HMO to purchase or build its own hospital facilities; HMOs can reduce community costs as long as hospital ownership permits HMOs to reduce their hospitalization costs;

where additional community beds are not needed, community costs can be reduced the most by requiring an HMO to acquire an existing community hospital in lieu of building a new one, if an appropriate existing hospital is available at a reasonable price;

when existing community hospitals are not suited to HMO needs or unwilling to sell at a reasonable price, community costs are reduced the most by delaying all new construction until additional beds are needed in the area and by giving the HMO first priority on construction when need appears. However, if the HMO, as a result of such delay, is likely to lose enrollment or otherwise not expand its enrollment, then community costs are reduced the most by permitting the HMO to build. In addition, reducing the need for fee-for-service beds by appropriate amounts enhances the savings still further; and,

where new beds are needed within the next 3-5 years (the lead time for construction of a new hospital), where the HMO has an enrollment in excess of 60 thousand members, and where the HMO has demonstrated an inability to purchase an existing facility under reasonable terms, community costs are reduced the most in the long run by permitting the HMO to build new beds. Community savings in the short run are sufficient to justify the construction of the hospital prior to an explicit need for more community beds.

We did not examine these factors for networks and IPAs because their enrollments typically have not been high enough to justify hospital construction. However, this characteristic may change in the future and may warrant closer examination.

d. Recommendations. Based upon our findings above, we developed recommendations affecting health planners' major activities, including health plan development, project review and health plan implementation. Our findings strongly indicate that HMO development is consistent with the long run health planning priority of cost control even though there may be
a slight increase in costs in the short run. In addition, we could find
no basis for concluding that HMOs achieve these reductions at the expense
of quality. HSAs concerned about the possibility of lower quality can
better address this concern by ensuring that consumers are informed about
publicly available measures of quality rather than preventing HMO develop-
ment. Generally, we recommend that health systems agencies:

- promote HMO development by allowing unrestricted entry of HMOs,
  encouraging potential sponsors, and eliminating local condi-
tions that inhibit HMO entry; financially viable HMOs will
  generally reduce long run community costs, and past experience
  shows that HMOs that are not viable close without adverse impact
  upon HMO enrollees. Active competition among HMOs appears also
to decrease community costs. Hence, HSAs should give a high
priority to competitive HMO development in areas where signifi-
cant community cost savings can be achieved. Such areas can
be identified by using local cost and utilization character-
istics and expected HMO enrollment projections with the com-
community cost-estimating methodology presented here. The most
important point here is for HSAs to understand that HMOs,
unlike hospitals, can reduce community costs in the long run
even though there is some duplication of investment in the
short run.

- address the potential problem of poor quality or accessibility
  which could result from unrestricted entry by emphasizing the
  public disclosure of information on HMO utilization rates,
  accessibility, and patient satisfaction; establishing and en-
  forcing quality standards for HMOs is the primary responsi-
bility of state licensing authorities, PSROs, state Medicaid
  agencies, and DHHS, in the case of federally assisted or
  qualified HMOs. More importantly, HMOs competing in the
  private group market are continually subject to scrutiny by
  prospective consumers. Hence, HSAs should adopt a quality
  assurance role that supplements rather than duplicates the
  activities of these bodies. HSAs can do so by cooperating
  with these organizations and consumer groups to make information
  that is collected on HMOs more readily available to the public
  in an understandable form. Because HMO quality is difficult
to predict prior to operation and difficult to observe and in-
  terpret subsequent to operation, this communications role for
  HSAs effectively complements existing quality controls.
In developing local area health plans, HSAs should include explicit provisions regarding HMO growth and development. Specifically, HSAs should:

- **establish an explicit need for HMOs in all areas where HMOs are likely to reduce community health care costs, using the methodology developed here.** Even where community costs may not fall, a need for HMO development should be established where less than 80 percent of the local population has an option to join an HMO. This definition ensures that, in areas where HMO development can reduce community costs, HSAs establish a clear need for HMOs even if over 80 percent of the population already has the option to join them. This approach encourages competitive HMO entries so that community savings are generated beyond the savings a single HMO could produce. In addition, in areas where community costs might not fall, the importance of making the choice of greater accessibility to primary care available is the primary concern. Although HMO operations may not be feasible in these areas, this definition ensures that sponsor interest or federal support is not discouraged or precluded on the grounds that community costs are not likely to fall.

- **establish an explicit need for both community and HMO beds which reflect expected HMO growth and development.** HSAs should establish explicit measures of community and HMO bed need so that bed need projections reflect the impact of lower hospital utilization rates of HMO members, and so that future requirements for hospital facilities by large HMOs are anticipated. By forecasting bed need in this way, HSAs can avoid the construction of too many community hospital beds and ensure that HMOs growing toward 80-100 thousand members can anticipate HSA reactions when they want to acquire their own hospital. This in turn enhances the community cost impact of HMO development by reducing the costs of supporting underutilized hospitals.

In project reviews of HMO requests for approval of new institutional health services (NIHS) and certificates-of-need, HSA criteria should reflect our findings about the ability of HMOs to reduce community cost. Specifically, HSAs should:

- **permit all HMOs to enter the local market or add new services, because financially viable HMOs will generally reduce community costs in the long run.** HMOs unable to control costs or enroll enough members to break-even will typically not reduce community costs. However, they are likely to go out of business and consequently pose little risk of raising long run costs due to a duplication of resources. Even if HSAs wish to restrict HMO entry, they should approve HMOs that are likely to reduce com-
munity health care costs in areas where the local health plan identifies a need for HMOs. HSA should also permit new HMOs to enter and compete with existing HMOs because active competition among HMOs generally increases community cost savings.

- approve all construction of outpatient facilities or purchase of new equipment by existing HMOs; HMOs, unlike hospitals, have no incentive to invest in facilities or equipment unless these purchases reduce long run costs of operation, or maintain or increase enrollment by improving the quality or accessibility of care. In some cases, outpatient or equipment expenditures might diminish the overall community cost savings available from HMO operation. However, in such cases, the community cost impact of these expenditures is relatively small. Finally, HSAs may be able to strengthen incentives for reducing community costs in the long run by giving HMO investments in outpatient facilities and equipment higher priority than traditional provider investments. Traditional providers facing such review criteria might consider HMO development opportunities more carefully under these incentives.

- approve all HMO requests to purchase, lease or otherwise acquire existing community hospitals regardless of the number of beds available or needed by the community; in all cases, HMO use of existing hospital facilities produces the greatest community cost savings. HSAs and SHPPAs can give large HMOs an added incentive to pursue this alternative by adopting policies to approve all such acquisitions. Some caution should be exercised where HMOs with fewer than 80,000-100,000 thousand members seek to acquire hospitals; however, HMO administrators advise us that this is most improbable.

- approve all HMO requests to construct hospitals where there is or will be shortly (3-5 years) a need for additional or modernized hospital beds; our analysis shows that community costs are reduced the most where HMOs can operate their own hospitals. Although HMO purchase or lease of existing hospitals is always desirable, it is possible that existing community hospitals are not well-suited to HMO operations because they are not located near HMO members, would require excessively expensive modernization, or are not available at a reasonable price. Thus, although HMOs have an incentive to purchase or lease rather than build if it is less expensive, they may not be successful in securing reasonable terms. In such circumstances, community costs are reduced the most where HMOs are permitted to build hospitals. In fact, HMO construction of needed beds reduces community costs more significantly than traditional provider construction of new beds.
- approve HMO requests to build a hospital in areas without any need for additional beds, when:
  - an HMO's ability to reduce community costs is severely hampered by use of existing community hospitals; and,
  - the HMO can show that existing hospitals are not suitable or not available at reasonable terms for sale or lease.

Our analysis of the community cost impact of hospital construction by an HMO showed that community cost savings are still obtained, even if an HMO builds its own hospital in an area with too many community hospital beds. Hence, HSAs should permit HMOs to build their own hospitals where the continued use of existing community hospitals threatens the HMO's financial viability or the maintenance of its current enrollment. This produces more significant community savings than letting the HMO fail, especially over the expected life of the hospital.

These recommendations are based upon a careful analysis of the community cost effects of HMO growth and development. Because the results vary from region to region and because BHPRD may want to extend the use of the methodology developed here, we recommend that BHPRD review and refine the models developed here to confirm their soundness and suitability. Particular attention should focus on:

- the verification and refinement of the community cost-estimating methodology presented here;
- the differential effect of federally qualified HMOs on community costs;
- the effects of HMO competition on premiums, community costs, and quality; and,
- the problems that face members of HMOs that close due to financial failure.

A careful review of these factors could greatly expand the applicability of the basic analysis presented here.
Mr. Preyer [presiding]. Thank you, Mr. Lane.
Mr. Segadelli has a statement, I believe [see p. 1040].

STATEMENT OF LOUIS J. SEGADELLI

Mr. Segadelli. I have submitted a statement and will not read from it. I would like to highlight two aspects of our experience which supports what Mr. Lane said.

GHA strongly concurs and endorses his comment. GHA takes care of 108,000 people in the metropolitan area of Washington, D.C. About 50,000 of them are residents of the District of Columbia, and about 30,000 are residents of Prince Georges and Montgomery Counties in Maryland and about 12,000 or 13,000 are residents of Fairfax County and Virginia. That is the basis of one of our problems and probably of HMO's in the planning process.

We had recent experience in Prince Georges County involving an ambulatory facility. In that quadrant of the Washington area we have about 31,000 people, 11,000 or 12,000 living on the Maryland side and 20,000 on the District side. We proposed to put an ambulatory facility in Marlow Heights, 2 or 3 miles outside the District. We went into the situation relatively naively and discovered belatedly that we were in a different fight, one which involved four separate meetings of the HSA and its committees.

Some of the opposition was very predictable. The medical society opposed us, the hospitals opposed us. You could attribute that to competition. One of the bases of opposition was a surprise. We lost a number of votes from the HSA and finally won by a vote of only 13 to 12 with a number of people abstaining on the building of a facility because we would not guarantee to hospitalize Prince Georges County residents, members of GHA in Prince Georges hospitals.

We were asked to distort our entire structure to meet local community needs. An institution which, in terms of the metropolitan area is regional, having to deal across at least four political subdivisions is at a very distinct disadvantage in trying to push forward its planning and meet its organizational needs against local interests which can mobilize very strongly in a given local area. I think this is an argument that adds to the need to exempt HMO's in the planning process if you are going to press the HMO concept.

The second experience involves our proposal to have a hospital in the District of Columbia. At about 108,000 or 110,000 members, an HMO seriously can begin to think about its own hospital and I think the statements by Mr. Lane and others will indicate that HMO's which have their own integrated system of inpatient-outpatient care—hospital plus ambulatory facilities—can provide a much more cost effective medical care delivery. We proposed to build a 180 bed hospital on Wisconsin Avenue and we filed an application about 2½ years ago. We won at least the neutrality of the local residents in their neighborhood advisory council and a fair number supported us and then we went to the planning agency then existing in the District, which is the State in this instance, and lost the effort in spite of the fact that the laws then on the books and still on the
books provide for special consideration for HMO's and preference for HMO needs. I have to say that, in our experience, these considerations were ignored, these and the first application was turned down strictly on the basis of the fact that the District was over-bedded. The District has been over-bedded for 3 or 4 years, probably a thousand beds more than the District needs, which is 20 percent of the bed complement.

That is also true of the suburbs and, if one says to HMO's in any area where there are more beds than are needed, you cannot build more beds than needed in the plan, an HMO or anybody else with an innovative plan that might come along in the future will be stymied. We are franchising hospitals just because they are there. We are saying that the present structure cannot be disturbed until such time as the number of beds comes into consonance with the plan. That will prohibit the development of HMO's.

We have, since the first application was turned down, come up with a very innovative idea. It will be interesting to see how that is met.

There is in the District of Columbia the Washington Hospital Center, a 900-bed hospital complex in about the center of the city in the central east, more or less. The Washington Hospital Center offered to us land on its campus site, approximately 2½ acres, on which GHA could build a 150-bed hospital. The rent would be nominal and the Washington Hospital Center has already done this kind of thing before. It had already brought to its campus the Children's Hospital, that now operates there.

In addition to that they have offered to give up 80 of their current beds to us if the city gives us the certificate to build. In exchange for this concession, we would agree to buy from the Washington Hospital Center what is called tertiary care, the more complicated medical care that is sometimes needed, in contrast to the greater number of confinements which only involve routine care. We would probably do our obstetrics in the Washington Hospital Center's obstetrics unit, which would lower the cost to us and to them and make the delivery much more efficient. We would continue to care for our children in the Children's Hospital right on the campus grounds. All of this would account for about 20 percent of our bed needs.

The remaining 80 percent, which are the more routine kinds of hospital care, we would provide in our own hospital—on their grounds. In addition to that, we would buy our utilities from them—that kind of service. So we think this is a very cost effective proposition, for both parties.

What we are pleading for is that, if we get turned down, if we have to go through the grinder of planning agencies and lose, that we have some recourse, some way to go. The last time around we met the unified opposition of all the existing hospitals in the District. We don't know what is going to happen the next time around, but we do know that we have been delayed 3 or more years and the cost of providing our own hospital has gone up 30 or 40 percent as a result of inflation alone and we are not able to provide the kind of cost effective efficiencies we think we ought to be able to offer.
Therefore, we join with the Kaiser organization in urging the exemption of HMOs from the Planning Act because we think we can do the job better for our own enrollees, while providing a competitive yardstick for other health providers in the greater Washington area.

Thank you, Mr. Chairman.

[Testimony resumes on p. 1046.]

[Mr. Segadelli's prepared statement follows:]
STATEMENT BY
LOUIS J. SEGADELLI, EXECUTIVE DIRECTOR
GROUP HEALTH ASSOCIATION, INC.
WASHINGTON, D. C.

GOOD MORNING, MR. CHAIRMAN. I AM LOUIS J. SEGADELLI, EXECUTIVE DIRECTOR OF GROUP HEALTH ASSOCIATION OF WASHINGTON, D. C. IT IS A PRIVILEGE TO APPEAR BEFORE YOU AND DISCUSS SOME SPECIFIC PROBLEMS RAISED FOR GROUP HEALTH BY THE U. S. HEALTH PLANNING & RESOURCE DEVELOPMENT ACT OF 1974.

GROUP HEALTH ASSOCIATION, OR GHA, AS IT IS USUALLY CALLED, IS IN ITS 41ST YEAR OF SERVICE AS A HEALTH MAINTENANCE ORGANIZATION (HMO). IT IS A 40 MILLION DOLLAR BUSINESS THAT NOW SERVES MORE THAN 108,000 WASHINGTON AREA RESIDENTS, PRIMARILY THROUGH ITS FOUR (SOON TO BE FIVE) MEDICAL CENTERS. GHA IS A MEMBER OWNED, FEDERALLY QUALIFIED, NON PROFIT HMO.

WE ARE HERE TO URGE THAT THE PLANNING ACT BE AMENDED TO ALLOW HMO'S LIKE GHA TO PLAN AND BUILD THEIR OWN HOSPITALS AND HEALTH CENTERS FOR THEIR OWN ENROLLED POPULATIONS, WITHOUT HAVING TO APPLY TO THE LOCAL HEALTH SYSTEMS AGENCIES FOR CERTIFICATES OF APPROVAL TO PROCEED WITH SUCH CONSTRUCTION, AS REQUIRED BY THE HEALTH PLANNING ACT. THE LENGTH OF CERTIFICATE OF NEED REVIEWS HAVE PROVEN VERY COSTLY TO GHA AND OTHER HMO'S. OUR FIVE YEAR HOSPITAL PLAN HAS BEEN ABORTED AND OUR HEALTH CENTER DEVELOPMENT RETARDED BY THIS REQUIREMENT.

COMMON ECONOMIC SENSE KEEPS HMO'S FROM BUILDING MORE OR LARGER FACILITIES THAN THEY NEED. SINCE HMO'S SERVE ONLY THEIR ENROLLED, PREPAID MEMBERS, IT IS AGAINST THEIR FINANCIAL INTEREST TO BUILD EITHER A HOSPITAL OR HEALTH CENTER LARGER THAN THEIR CURRENT ENROLLMENT AND THEIR GROWTH PLAN INDICATES IS ECONOMICALLY
SOUND. GHA'S EFFICIENCY AND ITS ABILITY TO CONTROL COSTS ARE TIED DIRECTLY TO MAXIMUM CONTROL AND OPERATION OF ITS OWN HEALTH CARE DELIVERY SYSTEM, PARTICULARLY AS TO ITS OWN HOSPITAL, BUT ALSO AS TO OPERATING ITS OWN HEALTH CENTERS AND USING A FULL TIME MEDICAL STAFF.

OUR MUCH LOWER HOSPITAL UTILIZATION RATES WOULD ENSURE LOWER OVERALL HEALTH CARE COSTS TO THE CONSUMER IF WE OWNED OUR OWN HOSPITAL. WE ARE NOW AT THE MERCY OF GENERAL AREA HOSPITALS AND THEIR CHARGES. THIS COST ALONE AMOUNTS TO MORE THAN ONE-THIRD OF OUR OPERATING COSTS. DOCUMENTATION HAS BEEN SUBMITTED TO THIS COMMITTEE WHICH SHOWS THAT HMO'S WHICH OWN OR OPERATE THEIR OWN HOSPITAL(S) ARE, ALMOST WITHOUT EXCEPTION, MORE COST EFFECTIVE THAN HMO'S THAT DEPEND UPON COMMUNITY HOSPITALS FOR BEDS.

GHA'S FIRST APPLICATION TO THE WASHINGTON, D. C., DEPARTMENT OF HUMAN RESOURCES FOR A CERTIFICATE OF NEED TO BUILD ITS OWN HOSPITAL HERE IN THE DISTRICT WAS BEFORE THE DHR FOR NEARLY TWO YEARS BEFORE BEING REJECTED, BASED ON BED NUMBERS ALONE. THERE WERE OTHER FACTORS IN THE PROPOSAL WHICH AFFECTED THIS JUDGMENT, INVOLVING DOCTORS HOSPITAL, WHICH RECEIVED A GOOD DEAL OF PUBLICITY, BUT NEED NOT BE REPEATED HERE.

WE NOW HAVE A SECOND APPLICATION IN THE DISTRICT, JOINTLY SPONSORED BY THE WASHINGTON HOSPITAL CENTER, A 900 BED GENERAL HOSPITAL COMPLEX IN THE DISTRICT. WE ARE WELL AWARE THAT MORE THAN 1,000 BEDS HAVE BEEN VACANT EVERY DAY FOR NEARLY 3 YEARS IN THE DISTRICT OF COLUMBIA, ACCORDING TO THE AMERICAN HOSPITAL ASSOCIATION. THIS REPRESENTS ABOUT 20% OF THE AVAILABLE BEDS.
THE AHA ALSO REPORTS THAT 20% OF THE BEDS IN THE WASHINGTON SUBURBS ALSO HAVE BEEN VACANT EVERY DAY. EVERY JURISDICTION IN THIS AREA IS OVER-BEDDED. WHAT IS GHA TO DO? IS IT ENOUGH, AS SOME SAY, TO CRY "STOP - NO MORE BEDS FOR ANY REASON"? OR, DOES RESPONSIBILITY TO CONTROL THE NUMBER OF BEDS ALSO CARRY WITH IT RESPONSIBILITY TO SEE TO IT THAT EXISTING BEDS ARE WISELY USED AND MEET ACTUAL NEEDS? ARE WE GOING TO GIVE A PERMANENT FRANCHISE TO AN INSTITUTION JUST BECAUSE IT IS THEIR? FOLLOWING THE PRESENTATION BY GHA TO THE ADVISORY COMMITTEE TO D.C.'S HEALTH PLANNING AGENCY, RELATING TO OUR APPLICATION FOR A CERTIFICATE OF NEED TO BUILD A GHA HOSPITAL, A NUMBER OF THE MEMBERS OF THE COMMITTEE EXPRESSED THE VIEW THAT THEY HAD TO REJECT GHA'S APPLICATION, ALTHOUGH IT HAD MERIT, BECAUSE THEY WERE LIMITED TO DETERMINING ALLOWABLE NUMBERS OF BEDS. THEY HAD TO IGNORE WHAT SOME OF THEM KNEW - THAT ON THE WEST COAST, HMO'S (THE KAISER FOUNDATION HEALTH PLAN AND THE GROUP HEALTH COOPERATIVE OF PUGET SOUND) HAVE DEMONSTRATED THAT ONLY 2 BEDS PER THOUSAND ARE NEEDED IN A HOSPITAL BASED HMO, WHEREAS, IN PUBLIC PLANNING, 4 TO 5 BEDS PER THOUSAND IS THE NORM (NOTE HEW'S RECENT GUIDELINES). HOW IS THE EAST COAST AND THE WASHINGTON AREA, IN PARTICULAR, TO GET A DEMONSTRATION OF THIS FACT IF ALL NEW HOSPITALS ARE BANNED?

THE ISSUE IS IMPORTANT. THE WASHINGTON HOSPITAL CENTER AUTHORITIES HAVE MADE WHAT SEEMS TO US TO BE AN INGENIOUS AND USEFUL PROPOSAL, USEFUL TO THE CITY, TO WASHINGTON HOSPITAL CENTER, AND TO GHA. IT HAS OFFERED TO GHA AT A NOMINAL RENT A TRACT OF LAND ON ITS CAMPUS ON WHICH GHA WOULD BUILD ITS OWN HOSPITAL OF ABOUT 150 BEDS. THE WASHINGTON HOSPITAL CENTER WOULD GIVE UP 80 OF ITS BEDS TO GHA IF THE CITY WOULD AUTHORIZE THE OTHER 70 BEDS
TO GHA. GHA WOULD SEND ITS COMPLICATED CASES TO WASHINGTON HOSPITAL CENTER (7% OF ITS BED NEEDS), CONTINUE ITS PEDIATRIC CARE AT CHILDREN'S MEDICAL CENTER (3-4% OF ITS BED NEEDS), PROVIDE OBSTETRICS AT THE HOSPITAL CENTER (1% OF ITS BED NEEDS), AND PROVIDE 80% OF ITS MEMBERS NEEDS IN ITS OWN, LOWER COST HOSPITAL, ONE WHICH WOULD LIMIT ITSELF TO ROUTINE HOSPITAL CARE. WE WOULD GET OUR UTILITIES FROM ITS PLANT. WHY NOT BUY ALL ITS IN-PATIENT BED NEEDS FROM THE WASHINGTON HOSPITAL CENTER? BECAUSE, IT IS TOO EXPENSIVE. THE CENTER IS A MEDICAL TEACHING INSTITUTION WITH COSTS NOT TOO FAR BELOW THAT OF GEORGE WASHINGTON UNIVERSITY HOSPITAL AND GEORGETOWN UNIVERSITY HOSPITAL. ITS OVERHEAD COSTS INCLUDE SUCH ACTIVITIES AND CAPITAL ITEMS AS A LARGE RESIDENCY PROGRAM, THE WASHINGTON AREA'S BURN CENTER, A MILLION DOLLAR CAT SCANNER, AND OTHER USEFUL AND LIFE-SAVING EQUIPMENT. WITHOUT DISCUSSING WHO SHOULD BEAR THE COSTS OF THESE COMMUNITY ASSETS, GHA COULD NOT SHARE IN THEM AND SURVIVE IN THE COMPETITIVE MARKETPLACE. HOWEVER, GHA WOULD USE THESE FACILITIES AS NEEDED AND, IN THAT WAY, WOULD USE THEM IN A COST-EFFECTIVE MANNER. WE WOULD PROVIDE ROUTINE AND UNCOMPLICATED HOSPITAL CARE IN A MOST ECONOMICAL WAY.

MANY DIFFERENT KINDS OF INITIATIVES ARE POSSIBLE WHEN EXPERIENCED PEOPLE ARE ENCOURAGED TO INNOVATE. ARE THESE TO BE WIPED OUT BECAUSE THERE IS AN ABSOLUTE LID ON BEDS IN THIS AREA? PARENTHETICALLY, I MIGHT NOTE THAT THIS PROPOSAL CAN BE IMPLEMENTED WITHOUT TAKING AWAY ANY BEDS AND BY ADDING LESS THAN 10 BEDS TO THOSE NOW ON THE APPROVED ROLLS HERE IN THE DISTRICT. THE DISTRICT'S DHR DIRECTOR, MR. RUSSO, APPROVED A RENEWAL CERTIFICATE
FOR DOCTORS HOSPITAL AT ABOUT 60 BEDS LESS THAN ITS PRESENT AUTHORIZATION. TOGETHER WITH THE 80 BEDS THE WHC IS WILLING TO GIVE, THIS WOULD MAKE 140 OF GHA'S 150 BED NEED. AT ITS PRESENT RATE OF GROWTH, GHA WOULD OCCUPY ITS NEW HOSPITAL ON OPENING DAY AT A HIGH LEVEL OF OCCUPANCY AND BE AT CAPACITY IN LESS THAN 6 YEARS.

ANOTHER CONSIDERATION FOR THE D. C. HEALTH PLANNERS IS THE "BLEEDING" OF HOSPITALIZATION TO THE SUBURBS. PHYSICIANS WILL FOLLOW HOSPITALS AND POPULATION. IN SPITE OF THE FACT THAT EVERY SUBURBAN JURISDICTION IS OVERBEDDED, HOSPITALS ARE PLANNED, GOING UP OR RECENTLY COMPLETED IN FAIRFAX, PRINCE GEORGE'S AND MONTGOMERY COUNTIES; INDEED THERE ARE THREE SUCH IN PRINCE GEORGE'S. IN TIME, GHA WILL BE UNABLE TO SAY TO ITS MEMBERS IT IS BETTER FOR YOU AND GHA FOR YOU TO BE IN A D. C. HOSPITAL THAN IN A SUBURBAN HOSPITAL, IF WE ARE NOT TALKING ABOUT GHA'S OWN HOSPITAL, IN WHICH WE WILL HAVE RESPONSIBILITY AND CONTROL AS TO BOTH MEDICAL CARE QUALITY, PROCEDURES AND COSTS.

ANOTHER EXAMPLE: GHA WAS DELAYED FOR SEVERAL MONTHS LAST YEAR IN ITS PLAN TO BUILD A MEDICAL CENTER IN THE NEARBY MARLOW HEIGHTS (PRINCE GEORGE'S COUNTY, MD.) AREA - WHILE GOING THROUGH FOUR SEPARATE HEARINGS BEFORE THE HEALTH SYSTEMS AGENCY OF SOUTHERN MARYLAND CONCERNING OUR CERTIFICATE OF NEED APPLICATION RELATING TO THAT CENTER. ONE OF THE PROBLEMS - IN THAT AGENCY'S VIEW - WAS THAT GHA WOULD NOT AGREE TO HOSPITALIZE OUR PRINCE GEORGE'S-GHA MEMBERS IN PRINCE GEORGE'S COUNTY HOSPITALS. THIS WAS AT A TIME WHEN THREE NEW HOSPITALS WERE GOING UP IN THAT COUNTY - IN ADDITION TO ALL THE OTHER HOSPITALS ALREADY IN OPERATION THERE.
OUR POINT HERE IS THAT - WHILE OUR IMPACT UPON AREA PROVIDERS IS SLIGHT - IT IS A HEALTHY THING - ECONOMICALLY AND IN TERMS OF COMMUNITY SERVICES GENERALLY - TO HAVE COMPETING HEALTH CARE SYSTEMS OPERATING IN A NEIGHBORHOOD. ALSO, WHILE WE HAVE NO PROBLEM WITH BEING INSPECTED AND REGULATED BY HEALTH AGENCIES, WE DO HAVE PROBLEMS WITH BEING ASKED TO BAIL EACH OF THE LOCAL COMMUNITIES OUT WITH THEIR HOSPITAL BED PROBLEMS. WE SUGGEST THAT THE COMPROMISE POSITION WHICH WE HAVE ADOPTED IN REGARD TO OUR HOSPITAL NEEDS (SET FORTH ABOVE) WILL WORK OUT WELL FOR GHA, OUR MEMBERSHIP AND THE GENERAL MEDICAL COMMUNITY.

I CITE, WITHOUT ELABORATION HERE, THAT THE U. S. CONGRESS HAS RECOGNIZED THE POTENTIAL OF HMO'S IN PROVIDING MORE COST EFFECTIVE MEDICAL CARE IN THE HMO DEVELOPMENT ACT OF 1973 AND IN THE PUBLIC LAW 93-641 -- THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 -- AND, IN BOTH, REQUIRES THAT SPECIAL CONSIDERATION BE GIVEN TO THE NEEDS AND POSSIBILITIES OF HMO'S. WHAT WE SEEK NOW IS AN OPPORTUNITY TO FULFILL THAT POTENTIAL.

OUR PLEA, THEREFORE, IS FOR PLANNING WHICH DOES MORE THAN JUST MAKE A BED COUNT; WHICH ENCOURAGES NEW INITIATIVES; WHICH TAKES INTO ACCOUNT TRENDS AND DEVELOPMENTS AND WHICH FACES HARSH ECONOMIC FACTS. IN THE PRIVATE, COMPETITIVE SECTOR OF THE ECONOMY, COMPETITIVE FORCES ELIMINATE THE UNNECESSARY, THE INEFFECTIVE AND OBSOLETE. PUBLIC AUTHORITY NEEDS TO PLAY THIS ROLE IN THE FIELD OF MEDICAL CARE, WHICH IS NOT AS SUBJECT TO COMPETITIVE PRESSURES.

BOTH OF THESE LAWS NEED AMENDMENTS OF THE TYPE WE ARE SUGGESTING IF THEY ARE TO CARRY OUT CONGRESSIONAL INTENT.
Mr. Preyer. Thank you very much for a very informative presentation.

Let me ask you one question of sort of general interest not too directly related to what you are doing.

Mr. Lane mentioned there was no need to control the growth of HMO's. I was visiting an HMO in Winston Salem, the Reynolds industry. They don't call it an HMO, but that is what it really is. That indicated that that was the first corporate HMO since the Kaiser plan. Is that right? Has there only been one corporate foundation?

Mr. Lane. I believe that is correct. Our organization was sponsored by the Kaiser industry when it first started. It is much broader than that now. It covers 3.3 million people. There is a substantial increased interest among the corporate community in fostering the development of health maintenance organizations. The Ford Motor Co. is examining the possibility and a number of other large corporate organizations are and I think there will be increased interest.

One of the basic problems, when corporate managers start looking at the issue, is all the Government controls they have to go through to get established. That is something they have to look at carefully. Most of them are very amazed to find out what you have to go through to start and get approved for HMO in terms of Government approval.

Mr. Preyer. That is a very impressive operation they have. I hope your plan and that one will interest a lot of other corporations.

Just one question. You recommend that States be prohibited from including HMO's under their certificate-of-need laws. How many States have those laws that include them now?

Mr. Lane. I don't know that. I am sorry. I only know of the States in which we operate. We operate in six, two due and two are considering it. California will be considering it. It is my understanding a number of States in the East do.

Mr. Preyer. Those laws would allow an HMO to build a hospital even if the HSA found excess beds exist in that community; is that right?

Mr. Lane. The existing laws?

Mr. Preyer. If you exempt it or if States were prohibited from including HMO's under their certificate-of-need laws, that would allow an HMO to build a hospital even if HSA found there were excess beds?

Mr. Lane. Yes, sir. I would like to address your attention to exhibit 1 [see p. 1029] of our testimony, one of the basic arguments for not allowing HMO's to build when there are excess beds in the community is that it increases the cost to the community. The study portion of which is presented in exhibit 1 was done for HEW by ICF, Inc. It is a careful study of whether that is true. They found it is not true. Even where there is excess bed capacity in a community, the introduction of a cost effective HMO and the building of its own hospital will result in a total reduction of community cost. I think that is a very significant point.

Mr. Preyer. I can see your point, however as to how it will restrict innovative plans it does make a liar out of some of our statistics where we just say "X" number of beds in excess means "X" dollars of extra cost. It does not necessarily mean that apparently.
Mr. Lane. Yes, sir. I would like to give an example. The State medical facility plan guidelines which came out the middle of last year set as one of the highest priorities 80 percent occupancy. The country is running about 75 percent now or somewhat below that. If your major objective is to have the hospitals running at 80 percent occupancy, there are only two ways to accomplish that; that is close some beds in hospitals, secondly, have more people getting hospital care.

The problem is that it is unlikely, despite what may be in this bill at the present time, that hospitals will be closed by Government fiat in the near future, closing for other reasons but not Government fiat. If your objective is to keep occupancy higher and HMO proposes to build or expand and one of the characteristics of HMO is they have low utilization, utilize substantially less, they will fight that that objective of high occupancy because they will drive occupancy down. That is an important objective to drive occupancy down, not up.

I don't believe the planners understand that. Low occupancy is not bad. In California the hospitals run at 60 percent occupancy on the average, yet their days per use are 300 or less days of hospital care per thousand persons, more than 300 less than the national average. It is not evil to have low occupancy. It is important to have it until the beds come into balance. Our institutions don't run at high occupancy either but are cost effective.

Mr. Preyer. I didn't mean to cut you off, Mr. Walgren. We do have a vote.

Mr. Walgren. Maybe a couple of minutes.

First, it is my understanding that you would not need a certificate-of-need for any outpatient facilities developed by HMO; is that correct?

Mr. Lane. Under this proposal, that is correct.

Mr. Walgren. What are the difficulties of using presently existing hospital facilities by a developing HMO, are those mainly political problems of access?

Mr. Segadelli. For a developing HMO there is no alternative. It is because you don't have the membership or resources, but at a certain point it becomes possible but that becomes possible at an enrollment between 100,000 and 125,000. That is where we are. Then you can begin to achieve many economies which you can't achieve when using someone else's hospital. It is not a question of running the hospital better but you can eliminate a lot of duplication.

Mr. Walgren. What you are essentially doing, you are pulling patients away from the other hospitals at that point, you are competing for provision of services?

Mr. Segadelli. Sure.

Mr. Walgren. The question becomes whether or not those services should be provided with existing systems or whether a new facility that can provide certain economies of scale, a new administration process —

Mr. Segadelli. Not only economies of scale. For example, an HMO using a community hospital has to have its own medical records and have a medical record in the hospital, have its own X-rays and X-ray in the hospital, own lab tests and lab tests in the hospital, which if it
ran both it could provide in one way and it has to pay the overhead on whatever the hospital decides the hospital will have, whether the HMO thinks it is smart or not, CAT scanners, for example, or open heart surgery teams to get proliferated around the community.

I have essentially answered the question. I think there are savings in the HMO's having their own hospitals that are not only possible if they buy from other institutions and are not related to scale alone but to unnecessary duplication and overhead and things like that.

There are some other problems with using community facilities. In the first place, a bed is not necessarily a bed. All beds are not the same. They are not in the right places. You cannot use a pediatric bed for adults. Planners don’t take that into consideration. Even though there are too many beds they may not be the right kind of bed.

Second, the medical staff may be opposed. We have been trying to use hospitals in southern California. They go to vote with the medical staff, absolute opposition. In addition, there are other problems. The long-term relationship is very important. We have to build an ambulatory care facility beside the hospital to care for outpatients. Unless the hospital will enter into long-term arrangements, we can’t do that. Those criteria are set forth on page 7.

Mr. Walgren. Thank you.

Mr. Preyer. Thank you. We have to go vote now and will recess at this time until 2 o’clock this afternoon when the panel of equipment manufacturers representatives, I believe, will be the first up.

The committee stands in recess until 2 o’clock.

[Whereupon, at 12:30 p.m., the committee recessed, to reconvene at 2 p.m., the same day.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, presiding.]

Mr. Rogers. The subcommittee will be in order.

Continuing our hearings on health planning and resources development, we have a distinguished panel of Governors which we welcome to the committee and I would like to ask Dr. Carter first to have a comment or introduction.

Mr. Carter. It is my pleasure to introduce the Governor of the State of Kentucky, the Honorable Julian M. Carroll.

Thank you.

Mr. Rogers. We are honored to have you and Governor Herschler of Wyoming. We do appreciate both of you coming here to help the subcommittee. We are anxious to work with the Governors in trying to develop a health planning system that will be effective. I think it is a most important piece of legislation and we doubly appreciate your being willing to give us your time to be of benefit in our thinking.

STATEMENT OF HON. PULIAN M. CARROLL, GOVERNOR, STATE OF KENTUCKY

Governor Carroll. Mr. Chairman, Congressman Carter, Congressman Walgren, we appreciate the opportunity of coming today. I have an airplane that leaves here at 3 o’clock and will try to immediately proceed into my testimony.
I am going to not read it because obviously it is easy for me to file it with the committee and I will try not to take longer to explain it than it would be to read it.

Mr. Rogers. That will be a refreshing approach from some of the witnesses we hear. Your statement will be made a part of the record in full, without objection [see p. 1050].

Governor Carroll. We think that there are some movements that can be made in this legislature that would vastly improve our ability to make it work.

In Kentucky we were fortunate enough prior to the implementation of this legislation to have an excellent planning system. We have had it in operation in Kentucky for about 15 years. We have area development districts that were implemented in our Commonwealth about 15 years ago and those districts have been involved in health planning in our State for a long time. Thus, it was easy for us just to take those districts and divide them along their geographical boundaries and set up our HSA's and just go on to work.

We still do have some problems, though. In one particular instance we have three counties in the north side of Kentucky that I can't get the government of Ohio to let me have to put into my system. I did get the Governors of other States that have our counties to agree so we could operate as an entity. Because of the law and the other Governors, I have three counties under control of the Ohio legislature and we have to report six Ohioans on my State Board to oversee this statewide program. We believe that would then give them a disproportionate share of the oversight of this operation. Surely we don't think the committee ever intended that.

I am an old legislator myself, spent 10 years in the Kentucky Assembly, and beg forgiveness for my mistakes. I am essentially suggesting it is the kind of thing you could not anticipate would happen, but those are things that have happened to us.

Mr. Rogers. Have you suggested language in your testimony?

Governor Carroll. Not as such, Mr. Chairman, but we would be happy to do it.

Mr. Rogers. Thank you.

Governor Carroll. The Governors Association has, I am advised. That takes care of that particular problem.

Additionally, while at this time we are having no problem at all in getting along with the people involved in our two HSA's—we have two in Kentucky—nor do we anticipate any problem with our overall State coordination council, but we do seriously think that it has the great potential for fragmentation and disorientation because there is little or no involvement by State government, who after all, in our judgment, has the overall responsibility for implementing our health planning program in the State.

We have county health departments. We have regional health departments that we designate in some of our counties that have the capacity to reach into other counties that don't have our comprehensive care centers, which is one of the best examples of how not to set up something in Kentucky. We are now working on the problem of how to take those health care centers and make them work since we are losing Federal funding for them. We have that problem in the
current session of the general assembly. They are essentially independent bodies and essentially have just gotten reimbursement of Federal dollars through our State agency and we have had little ability to make them implement statewide policy programs, and so that is what we are fearful we are headed for with our current operation of the HSA’s if we don’t make some of the slight changes we are suggesting.

I guess one of the most important things for me to suggest to you in my testimony is that I do not believe that I can go to my general assembly and ask for appropriation of dollars, at present about $130 million a year in Kentucky, and then be able to implement our health planning programs in Kentucky without some authority to be a participant in the total policymaking function.

At the moment with the bill as we presently read it, the Governor is totally separated from the decisionmaking implementing State health planning policy, and we seriously think that the Governor ought to participate in that planning operation.

Mr. Chairman, I could cover some other elements, but they are covered in my testimony. I would prefer to use my remaining time to try to answer some questions for you and the members of the committee.

I thank you.

[Governor Carroll’s prepared testimony follows:]

STATEMENT OF GOV. JULIAN M. CARROLL, GOVERNOR, STATE OF KENTUCKY

CHAIRMAN ROGERS, GOVERNOR HERSCHLER, I am delighted at the opportunity to be here to discuss with you some of our concerns about the National Health Planning and Resources Development Act of 1974 [Public Law 93–641]. We recognize that the intent of this legislation is to upgrade nationwide our health planning effort, and to enact in each State certificate-of-need legislation. These are essential prerequisites for improving the overall level of health care in this country.

There are, however, problems with 93–641 which Congress was obviously not able to anticipate at the time the legislation was enacted. One of our major overall concerns is that the legislation did not recognize differences between the States in problems and needs, or the State’s previous efforts in health planning. Two of the major benefits of this legislation—comprehensive health planning and improved funding levels for planning—already were in effect in Kentucky in 1974.

Kentucky is divided into 15 standard districts, and all regional planning groups—such as Manpower, Aging, Criminal Justice, and Health—plan for the same geographic area. Our State agencies also are structured to offer services by district.

This system was in place in 1974, and each of our 15 districts was served by professional health planning staff.

As for funding, Kentucky in 1974 was supplementing the planning money available from HEW with funds from the Appalachian Regional Commission and a significant amount of State funds. In fact, the level of funding for our 15 health planning districts in 1974 was only $100,000 less than the funding for our health systems agencies during their first year of operation.

So Kentucky began implementing Public Law 93–641 from a position of strength. After some experience with its workings, we have found some problems which I would like to discuss today:

We feel that 93–641 circumvents the authority and expertise of State government, by setting up a direct relationship between the Federal Government and health systems agencies. It is inappropriate for private, nonprofit, self-perpetuating boards like the health systems agencies to have the kind of au-
tiority implied in Public Law 93–641 and in subsequent directives from HEW. It has been our experience that these boards should not administer Government programs without significant State oversight, monitoring, and technical assistance.

This kind of situation has created problems with our 15 mental health retardation boards which operate Kentucky's community health centers. These boards have used Federal funds and expanded programs to a level that cannot be maintained with State and local funds, now that Federal aid is winding down.

We think it is inappropriate that a citizens advisory group, the statewide health coordinating council, is allowed to submit health plans to HEW without the Governor's approval. After all, the Governor is the person who has the best overall concept of his State's needs, available alternatives, and resources.

The detailed requirements concerning health systems agency membership are too restrictive, especially the one that says a consumer on another board or committee becomes an indirect provider when considered for membership in a health system agency.

Some of Kentucky's leading citizens serve on a local emergency medical board, a hospital board, or local health department board, but they could not be considered for consumer appointments to a health systems agency.

Our existing certificate-of-need law in Kentucky is one of the best in the Nation. We are concerned that 93–641 and subsequent regulations will necessitate changes in the legislation. Kentucky enacted a certificate-of-need law in 1972. We feel that it is a good law and that it has been effective in controlling expansion in construction and services.

The law's provision for maintaining standard metropolitan statistical areas without the concurrence of the Governors involved also has caused Kentucky some problems.

As you know, the population base for health systems agencies was established at 500,000 with the possibility of waivers for smaller agencies in some cases. The legislation also said that if the Governors of neighboring States agreed to split a standard metropolitan statistical area, the Secretary of HEW could grant a waiver.

Although we had reservations about the population base for health systems agencies, we decided not to make an issue of it but rather chose to designate two agencies, each with a population of roughly 1½ million people. The Commonwealth of Kentucky was basically divided down the middle with an eastern and western Kentucky health service area.

We felt that this would enable us to coordinate health planning on a wider basis. But we also felt sure that the health systems agencies, once established, would build on the foundations developed by the 15 districts. In fact, both of our agencies have recognized the boundaries of the old districts as their sub-area council areas.

The standard metropolitan statistical area provision was a much more significant problem, and we requested waivers for all areas in which we were involved. With one exception, all of the Governors involved agreed with our request.

HEW approved all of our requests except the three counties in northern Kentucky adjacent to Cincinnati, Ohio. We submitted a redesignation plan last year calling for reuniting Boone, Campbell, and Kenton counties in Kentucky with the eastern Kentucky health systems agency, and we are still awaiting a final decision.

Our desire for redesignation should not be interpreted as opposition to interstate planning. We are committed to complete cooperation with our neighboring States in planning for the population of all five standard metropolitan statistical areas.

We think that adequate cooperation could be achieved through interagency coordination at the State level and between the health systems agencies, and we would be happy to pursue an interstate compact agreement with the State of Ohio in this regard.

Without redesignation, an Ohio-based health systems agency which represents 300,000 Kentuckians would have equal representation on our statewide health coordinating council with our eastern and western Kentucky health systems agencies, each with populations of approximately 1.5 million people.
Neither the law nor subsequent regulations require that Kentuckians be nominated. I could be forced to appoint six citizens of Ohio to our statewide health coordinating council.

We believe that, with some modification, 93–641 can work. We suggest your consideration of the following amendments:

The State should have more opportunity for significant contributions to the final statewide health plan. As it is now designed, the State health plan is merely a composite of health systems agency plans and the State is not an equal partner in formulating it. Also, we feel that a plan should not become final until it has been approved by the Governor of the State.

The Governor, and not the statewide health coordinating council, should make the final recommendation concerning approval or disapproval of any formula grant to the State.

The Governor should be allowed to name the chairperson of the statewide health coordinating council.

The council’s recommendation concerning Federal funds allocated to the States should go to the Governor and not directly to the Secretary of H.E.W.

The consumer criteria for membership on a health system agency should be less rigid.

All Governors involved should be required to agree to maintain an interstate standard metropolitan statistical area within the same health service area. Without such agreement, the metropolitan area should be automatically split.

The present time frame provided for review of certificate of need applications is inadequate and it should be extended to allow a 180-day review cycle.

Without these amendments, we seriously question the long-range effectiveness of Public Law 93–641. There is a strong implication in the legislation as it currently exists that State government is not to be trusted, and that a separate system outside State government must be set up in order to provide quality health planning and to contain costs. We believe that the Kentucky experience refutes this belief. Our health planning efforts have been effective because of the development of a local-State partnership, and we think this partnership should be encouraged at the Federal level also.

Thank you.

Mr. Rogers. Thank you. We appreciate your helpful suggestions.

Dr. Carter.

Mr. Carter. Thank you, Mr. Chairman.

When this became a law, Governor, I realized that we had area development districts, and I did my best to make an imprint on the law to that effect. It was rather difficult, but we did provide that, under certain conditions, recognition of previously-established planning districts would be allowed. In fact, Bill Alexander, the Honorable Bill Alexander from Arkansas, even went further on the floor of the House to make this possible.

I personally, well, I hope it is working the way we planned with the HSA’s for the two parts of the State. I support your idea of taking the three counties. You would like those counties to be in the eastern HSA; is that correct?

Governor Carroll. That is correct.

Mr. Carter. I think that we could very well do that. Again, I want to compliment you on what you said about the comprehensive care centers. I think you need assistance there.

You are talking particularly in reference to mental health; is that correct?

Governor Carroll. Yes, sir. That is correct, Dr. Carter.

Mr. Carter. You don’t think—I brought this up before the chairman before, this very thing you are talking about. Tell us a little of the difficulty you are having, if you would like.
Governor Carroll. I would love to. This may be slightly off the major subject matter, but I know it is an area the committee is much concerned with. Our comprehensive care centers in Kentucky are operated as independent self-perpetuating boards of citizens and, of course, they merely set up their own budget and then under Federal criteria apply to us for reimbursement. We have had a terrible time trying to audit them and stay abreast to make sure they spend their dollars properly. That is our only control over them. That is the approval of their dollar expenditures. They are not accountable under our State merit system or the State purchasing system, not accountable under the State transportation system and they really have had a lot of fraternizing in our State where one scratches the back of the other to the extent it has caused some embarrassment in the past.

We think we have solved most of those problems but the immediate problem now in trying to resolve their continued funding is we already have county health departments and regional health departments and now we have a comprehensive center that is somewhat duplicative of our own State-funded functions. So we are trying to resolve that present duplication between the two of them.

Mr. Carter. You really think we should take existing State agencies and build on them.

Governor Carroll. Yes, I do.

Mr. Carter. How about these comprehensive health centers, have they been effective in drug abuse or alcoholism? I understand they were set up for those two things especially, and for mental health.

Governor Carroll. They have been effective. Obviously some have been more effective than others where they had good personnel, good management personnel and good citizen boards.

Essentially that brings on the major problem. There is no capacity on our part to make sure that they all operated efficiently because other than our flow of dollars, which after all was an after the fact, you know when you work under a reimbursement procedure, we are simply trying to audit their previous expenditure of the dollars and then our only control over them is the future flow of other reimbursed dollars.

So as long as you are always paying the money after it has been spent, it is a little difficult to get them to correct procedures wherein we find faults.

Mr. Carter. Governor, I want to say that in some areas these centers are very helpful. I can name one that is based in Corbett and one in Somerset that are quite good. I have had extreme difficulties with some others and I just don't see that they have done anything about alcoholism or about drug abuse, one particularly which involves my area and that of another Congressman. I am sure you are familiar with it, but certainly I agree with you somebody that should take the trouble to make these programs work.

Governor Carroll. I would make one other assessment because I think it is so applicable to our HSA problem. I am often amused by somebody telling me, "All you want to do is play politics with something," I have been in public service for 18 years and the only distinction I have ever found in the use of the word "politics," first
of all, is whether or not it is in the public interest or in somebody's private pecuniary interests.

I try to deal with politics in the public interest as I know Congressman Carter does. The difference I find between a State government being involved in this, or a self-perpetuating board, is whether we play State government politics or the State board politics. You never remove politics totally from any operation. The question is whether they are applying mine or theirs. That is to put it simply.

We want those boards to be responsive and not be like these three comprehensive care center boards who are self-perpetuating and are not responsive. Some of them are but most are not.

We want to make sure that these HSA boards are responsive to the people that they serve.

Mr. Carter. The Kentucky Mental Health Association has stated that these programs were not too effective in some areas. The executive director of KMHA in Louisville visited with me. They are very fine people who strongly back the program but the most effective part has been the program for mentally retarded children as far as I have seen. There are others in our system. The nursing system has been excellent in some areas where we have provided service to home-bound people.

Thank you very much.

Governor Carroll. Thank you.

Mr. Rogers. Mr. Walgren.

Mr. Walgren. No questions.

Mr. Rogers. I assume you have a certificate-of-need board in your State?

Governor Carroll. Yes, sir, a fine certificate-of-need board. The Governor appoints the board but its decision is final. I have no authority to overrule or veto the decisions of that board. It has been in operation since 1972.

Mr. Rogers. You probably prefer not to have that authority.

Governor Carroll. You are totally correct. I prefer not to have that authority. Quite frankly, the law that now places it into the department creates a problem for us. We just as soon it be left to our major board and, quite frankly, there are some misinterpretations of the applications approved by those boards. Ours is often criticized because they approve most of the applications that come before it. As a practical matter, if the application isn't worth much, it never gets there because we have about four methods it must go through to get there and they work so much with the staffs, knowing their application may be denied. Rather than letting it be denied they withdraw it because they don't want to come before the board with a previously denied application. We have found it works very, very effectively in Kentucky.

May I add a slight comparable is we now have legislation before our general assembly in Kentucky I am going to support for cost containment, creating our own cost containment board in the Commonwealth.

Mr. Rogers. We commend you for that because this committee is hopeful the States will move and in the legislation Dr. Carter and I proposed——
Governor Carroll. I appreciate your saying that.

Mr. Rogers [continuing]. We have the mechanism for the State to come in and do their own cost containment, which we think is better.

Thank you for being here. Your testimony has been most helpful. We may be back in touch to get some of your thinking on things as they come up.

Mr. Carter. The director of that association is Ashley Tulles.

Governor Carroll. Right.

Mr. Rogers. Now, we are very pleased to have the distinguished Governor of Wyoming, the Honorable Edward Herschler.

We welcome you and thank you for coming.

STATEMENT OF HON. EDWARD HERSCHLER, GOVERNOR, STATE OF WYOMING

Governor Herschler. Thank you, Mr. Chairman.

I am very grateful for the opportunity to be able to appear here today and discuss the problems of the National Health Act.

I have a statement and will cover parts of it [see p. 1056], but hopefully there are other matters we can go into.

Mr. Rogers. That will be fine.

Governor Herschler. Let me preface my remarks by stating that Wyoming has a single statewide health agency. Consequently, I think most of my remarks will be directed in regard to that particular situation.

We are concerned there with the interrelationships between the health systems agency, the State health planning and development agency and the statewide coordinating council. It is a system with a single statewide health systems agency and there is a relatively complex relationship and interaction among those various agencies which I do not believe the Federal Act seriously concerns itself with or even contemplated when this was done.

In effect, the health systems agency now assumes the role of the state-level agency and by doing so has authority, as I see it, to exceed a state agency in the relationship of health care.

What I am here today for was to see whether my State or other States with a similar situation could take advantage of section 1636 of the law. I presume to become involved in that area so we would not have a health systems agency in Wyoming.

As you know, the law, as it now exists, complements or allows the State of Rhode Island and the territories to come under section 1536 and so what we are doing here, we are asking that Wyoming be permitted to take a waiver under section 1516 or possibly as an alternative to permit my State to have two health systems agencies within the State, although we would prefer to be able to take advantage of 1536. The next best bet we feel would be to have two HSA's in our State.

I think what I have done basically in my State is to have the State health coordinating council as part of the same members of the HSA. I was able to work with the group and made those original appointments and then also appointed an executive council of the HSA.
The reason I have done that is a matter of economics in our State. We have only a population of less than 400,000. We have 100,000 square miles so you can see what we have in our State.

The health system agency already spent about $22,000 of its budget of $175,000 for travel. So this is why I have not added additional people. It is a matter of economics.

Another problem that we have on this particular situation is the trying to find people to serve on this committee. Many are, as you know, required to be consumers and providers and many of those consumers and providers are self-employed and we find it very difficult to get people to keep any interest in this by having to attend at least two meetings a month and travel great distances. So actually only the larger health care providers, the rich, I suppose, or the retired tend to accept these nominations and appointments to SHCC or HSA.

One of the other burdens we have is I am able to appoint 40 percent of the people to SHCC and 60 percent come from HSA. If we follow this line of reasoning, it creates antagonism, I suppose, to the State.

So basically I would urge the committee, if it will, to recognize either that we should be able to get a waiver under 1536 or to have two HSA's. I will leave the balance to your questioning, sir, if you have any questions, and I will leave my prepared statement with you for the record.

[Governor Herschler's prepared statement follows:]

STATEMENT OF HON. EDWARD HERSCHLER, GOVERNOR, STATE OF WYOMING

Mr. Chairman, My name is Ed Herschler. I am the Governor of the State of Wyoming. I am grateful for this opportunity to testify on our experience with the National Health Planning and Resources Development Act of 1974. Let me preface my remarks by stating that Wyoming has a single statewide health systems agency. Consequently, my statements will be directed toward this type of structure.

I am deeply concerned about the interrelationships among the Health Systems Agency, the State Health Planning and Development Agency, and the Statewide Health Coordinating Council. In a system with a single statewide health systems agency, the relatively complex interaction among the various agencies as contemplated by the federal Act becomes seriously imbalanced.

In effect, the Health Systems Agency assumes the roll of a state-level agency with authority exceeding that of the state agency. Since there is only one health systems plan, the state agency need only add those programs totally financed by the state in order to have a complete state health plan. Proposed revisions are unlikely to be approved by the Statewide Health Coordinating Council since the executive committee of the Health Systems Agency is the Council. This incestuous relationship is carried to the point where the same person is the chairman of both organizations. The net result of this structure will be a wasting of finite health planning resources due to the nearly total duplication of efforts and the unproductive conflict that has been created.

The duplication does not end in the planning phase but continues throughout the review process. In those states with several health systems agencies, this overlapping of functions serves as a useful coordinative mechanism. However, in a state with only one health systems agency, there is little need for coordination. Thus, the only effects of the additional reviews are an increase in the bureaucratic burden placed on the citizenry and the creation of conflict between the two planning agencies.

The one major function of the health systems agency which is not duplicated in some manner by the state agency is the annual implementation plan. This
document becomes a statewide policy plan in Wyoming. Under the current provisions of the Act, priorities established in this plan are binding on the state agency. Consequently, the health systems agency can determine state policy without any input from state officials or agencies. I believe this situation goes considerably beyond the intent of the law.

In the spring of 1975, I appointed a committee to look into the requirements of this new legislation. The committee was composed of consumers and providers from throughout the state. After much discussion and deliberation, they recommended that Wyoming should seek inclusion under section 1536 of the Act, which would eliminate the need for a health systems agency. We were told by federal officials that this section applied only to Rhode Island and the territories, and that we should not waste their time and ours by pursuing that course of action. In retrospect, I regret not having insisted on the application for a waiver under section 1536.

My intent is not to malign the good people who have worked diligently as members of the boards governing the Health Systems Agency and the Statewide Health Coordinating Council. Under the circumstances, they have done an excellent job in implementing the law.

I do not question the applicability of this legislation to those states having more than one health systems agency. I cannot speak for them.

The achievement of equal access to quality health care at a reasonable cost is a high priority in the rural states where health resources are so scarce. Thus, my concern is not with the intent of the law.

However, I sincerely believe that the single statewide health systems agency structure inherently contains the seeds of conflict between the State Health Planning and Development Agency and the Health Systems Agency staff. My fear is that this discord will overshadow the planning efforts by these two agencies. In the end it will be the people of Wyoming who will suffer.

My request is that you consider the factors I have presented here today during your deliberations of amendments to the Act. Please review the appropriateness of the structure and authority currently contained in the law, as it is applied to states with a single health systems agency. I think you will conclude that states, such as Wyoming, will be served best by inclusion under section 1536. The intent of the law will remain, but the source of conflict will be resolved.

Thank you.

Mr. Rogers. Thank you very much for the points you have raised for consideration of the committee.

Dr. Carter.

Mr. Carter. It is interesting to note that the recent GAO report recommended there be no single HSA States. That is the General Accounting Office, an arm of the Congress. GAO recommended that those States either receive a 1536 exemption and have only a health planning agency and no HSA’s, or those States should have at least two HSA’s.

Governor Herschler. That is right.

Mr. Carter. Mr. Chairman, I believe that the law actually provides that States such as Wyoming can have two HSA’s if they want them, and if they can prove the need for them, because we had that in mind. You remember that we worked with such a thing in mind and it was brought up on the floor, It is a question of HEW putting it into effect, as I see it, Mr. Chairman.

If it is necessary, I would help to legislate on this question because you do have a large State, and the problems of getting together, if you can get people to serve, are monumental.

Governor Herschler. That is true.

I might add when this law was implemented, so far as our State was concerned, I am sure you realize it is a very complex and, if
you will, a confusing law, sir. I think that we were under the impression at least that we were required to make a decision at that point in time as to how many HSA's we wanted in our State. We felt in the interest of economics and considering the scarcity I suppose of population, we thought one HSA would be the right way to go. We feel now that that was not a correct decision, that we should be permitted, if we are able to do so without any problems, either to have two HSA's or being able to take advantage of the section 1536. We think our system as it originally was structured at the time this bill was enacted that we meet all the qualifications of 1536, it would be logical to be exempt.

Mr. Rogers. I think the committee certainly wants to be helpful. I was just wondering, if you do qualify under 1536, how do you get broad citizen input?

Governor Herschler. What I would plan to do, Mr. Chairman, is if that occurred, that with your State's Health Planning and Development Agency, that I would include then the members that are presently on SHCC continue with them so there would be citizen input along with our State agency. I think there would be coordination and cooperation which would be very helpful to us. So we would include our present members on the SHCC Council.

Mr. Rogers. It is my understanding that you would either want to qualify for that exemption or have two agencies.

Governor Herschler. Yes; one or the other. We would prefer to come under 1536. If that is impossible, we would prefer to have two HSA’s.

Mr. Rogers. Governor, thank you. We appreciate your being here and taking time from your busy schedule to do so. We look forward to working with you in this area.

Thank you so much.

Our next witness will be a panel of manufacturers representatives. Mr. Robert G. McCune, division manager, Radiation Imaging Product Division, National Electrical Manufacturers Association; and Mr. Harold O. Buzzell, who is president of the Health Industry Manufacturers Association.

We welcome both of you to the committee. Your statements will be made a part of the record, and you may proceed as you desire.

STATEMENTS OF ROBERT G. McCUNE, ON BEHALF OF RADIATION IMAGING PRODUCTS DIVISION, NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION (NEMA); AND HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Mr. McCune. Thank you.

I am here as a representative of the Radiation Imaging Products Division of the National Electrical Manufacturers Association (NEMA). This divisional trade group consists of 54 manufacturing companies of conventional medical and dental X-ray, diagnostic ultrasound, computed tomography, nuclear imaging and therapy medical technological equipment. In my brief comments today I
would like to share with you our industry views concerning national health planning.

My comments will be a brief summary.

First I would like to offer for your consideration several changes to H.R. 10460. We would propose that:

In section 202, dealing with National Health Priorities, under section 1502, that in the proposed paragraph (11), the word "under-utilized" be inserted between (of) and (duplicative);

In section 202, National Health Priorities, under section 1502, that paragraph (12) be revised to include the words "cost effective" between the words (of) and (policies);

Under section 218, certificate-of-need programs, that paragraph (7) of the proposed section 1527 amendment be revised as follows:

(7) For purposes of Sections 1523 and 1527, the term "major medical equipment" means single use medical equipment which is used for the provision of medical and other health services and which costs in excess of $200,000.

In the first suggestion we feel that the inclusion of "under-utilized" will better clarify this priority by establishing more defined criteria than simply "duplicative."

The second suggestion of including the phrase "cost effective" we hope will encourage HSA's to carefully distinguish between policies for purposes of mere implementation and policies that will in fact work toward achieving efficient local solutions relative to problems of health care costs.

Our suggestion for redefining "major medical equipment" in paragraph (7) of the certificate-of-need programs section of the bill is due to the concern that in smaller hospitals, for example, construction of a new multiple patient service room would be requested under a normal certificate-of-need process. But the HSA could also ask for a listing of all the numerous but different types of medical equipment to be used in the patient medical room. If all the installed individual medical equipment were to be considered as an aggregate, it could result in a total dollar figure reaching or exceeding the certificate-of-need requirement for major medical equipment. We have also suggested that the certificate-of-need dollar threshold for major medical equipment be only that equipment in excess of $200,000. We believe this should be considered to avoid the inclusion of lower cost basic medical equipment not envisioned to be covered under the certificate-of-need requirement. Such a dollar level would then allow the local HSA to deal with only major medical equipment of the high dollar-high technology type that is of concern.

We support the efforts of this committee to insure that national and local health planning is an effective approach to achieving a much needed reduction in the health care costs of this country. We would only ask that the role of medical technology be considered a necessary component of all such efforts to contain the rising costs of health care delivery, rather than being too often denounced as a major contributor to these increasing costs. Extreme indeed, when you consider that the diagnostic imaging equipment industry represents only about 0.6 percent of total health care expenditures.

I think there is widespread agreement that the twentieth century biomedical research and technological innovation have been re-
sponsible for profound improvements in human health. Some diseases have been eradicated; others can now be prevented; life itself has been extended; and much pain and suffering has been alleviated.

Further, I believe it fair to say that in a number of areas hospitals will have to look to greater utilization of medical technology to effect cost savings. It will be needed in more efficient and accessible emergency centers and out-patient clinics. It will be needed to replace older equipment with high operating and maintenance cost in order to reduce hospital expenses. It is also possible that some hospitals will have to turn to medical technology under new cost reduction measures in order to maintain adequate and safe patient monitoring. Yet, these same hospitals will be faced with artificial limitations on the use of new technology.

We would urge the Congress, and particularly this committee, to be sensitive and alert to any health planning cost containment policies that could inhibit the growth of medical technology, thereby institutionalizing inferior procedures and inefficient practices.

We also believe that another serious question that should be addressed is, what will the impact be on the development of new technology to meet future needs? Obviously, such development is an expensive undertaking with considerable commercial risk. It will become even less attractive to an independent technology manufacturer if its fair market potential is to be arbitrarily reduced or indirectly capped. Health planning legislation could well carry a secondary effect as to whether new technology is to be limited and also how the development may need to be funded.

Some of the concern I have expressed here today I think is best illustrated by the recently published revised proposed National Guidelines For Health Planning. We are specifically concerned with the proposed standard on computed tomographic scanner, but of more importance is the questionable logic of the whole procedure and basis for decision for many of the standards dealing with technological services and facilities.

On the guidelines for CAT scanners, it appears that this proposed HEW standard will be promulgated without full comprehension of the effect of the so-called minimum standard on the use of this technological equipment. Simply stated, the proposed CAT scanner standard will inappropriately restrict proper access to this proven diagnostic medical technology and serious put in question the industry’s interest in further pursuing state of the art technology.

In terms of the major procedural issue I mentioned I would like to share with you the following facts. In late summer, 1977, an HEW study team was organized with representatives from the office of the Assistant Secretary for Planning and Evaluation and the office of the Assistant Secretary for Health. The study team was asked to conduct a month-long phase I study of DHEW systems approach to technology management. This phase I study, “Health Technology Management at the Department of Health, Education, and Welfare,” was completed on or about November 7, 1977, in draft form as a report to the Secretary.

Because of DHEW’s recent release of revised proposed National Guidelines For Health Planning, and because the majority of the
proposed guidelines deal with technological services and facilities, it is disconcerting to me to note some of the comments contained in the DHEW phase I study, "Health Technology Management at the Department of Health, Education, and Welfare," contained such comments as:

**INTRODUCTION**

What market incentive mechanisms can be used to stimulate development of lagging or absent beneficial and cost-saving health technologies?

The "action" agencies of HEW (e.g., BHPRD, medicare, medicaid and PSRO programs) lack both the staff to do technical evaluations of technologies and the links to knowledge development agencies through which they could ensure examination of technologies for which they need action-supporting information.

Much effort is placed on efficacy and safety evaluation, but considerably less is done about cost-benefit, cost-effectiveness, or general societal impacts of technologies.

The strategy recognizes that, at the Department level, we cannot hope to systematically address all existing and emerging medical technologies, expert estimates of which range of 8,000 to 150,000.

DHEW decisionmakers and other users are unable to effectively locate and use much of the new and existing information about technologies because they are unaware of its existence; it is not in a form understandable to them; or they lack the resources to integrate such information and bring it to bear in a timely manner.

BHPRD develops standards for access, supply and distribution (through the National Health Planning Guidelines) to assist State and local health planning bodies. A major problem cited by nearly every agency developing or using standards is the need to implement viable standards as quickly as possible and the inadequacy of the technical knowledge base for doing this. In part, this state of affairs can be attributed to pressures to produce standards without delay. However, these failures will not be overcome without a far more integrated process.

In fairness, I believe this study is a positive effort to provide the proper technical expertise to HEW in order to properly assess technology in terms of patient and cost benefit. However, in the interim, it does evidence some support for the contention that health planning cost containment policies need careful analysis to insure a balanced objective on the growth of medical technology. There can be effective health planning with health care cost containment, but it should also facilitate, not impede, the research and development of technology.

Before closing, I would like to offer the following recommendation for your consideration.

Amend section 1503 of Public Law 93-641, National Health Planning and Resources Development Act, to increase the membership of the National Council on Health Planning and Development from 15 to 16 members. This would facilitate the addition of a qualified technology representative from the health care industry for purposes of bringing professional experience to the deliberations and recommendations of the National Council, particularly with reference to the National Council's responsibility for "(3) an evaluation of the implications of new medical technology for the organization, delivery and equitable distribution of health care services."

Thank you for the opportunity to appear here today and express these views.
Mr. Rogers. Thank you very much, Mr. McCune, for a helpful statement and your suggestions.
Mr. Buzzell.

STATEMENT OF HAROLD O. BUZZELL

Mr. BUZZELL. Good afternoon, Mr. Chairman, and you, too, Dr. Carter. It is good to see you again.

My name is Hal Buzzell and I am president of the Health Industry Manufacturers Association. Our 260 members produce virtually every medical product used in the health care system. These range from crutches to bandages to disposable plastic and paper products, to clinical laboratory products used to measure blood sugar, to surgical instruments and artificial hips, to computerized diagnostic equipment like the CT scanner. The industry numerically has relatively few giants; for example, the bulk of HIMAs’s membership—75 percent—has annual device and diagnostic sales of under $10 million.

I would like first, in launching my discussion on the proposed changes in legislation before the subcommittee, to simply state that we support the health planning process and we support that with emphasis on the local level. Your actions 4 years ago in establishing this process are certainly beginning to show dividends. This will be evident in our discussion on certificate-of-need (CON) approval rates for computed tomographic scanning equipment in a few minutes.

Health planning should encourage cost-effective patient benefits. All of our companies are affected by the health planning system to one degree or another. We understand the importance of planning; sound corporate management demands it. Simply said, our specific interest in the health planning system is that it encourage the appropriate introduction of cost-effective medical products and supplies so that the fruits of research and product development can be translated into patient care.

Therefore, it is our concern that the health planning process proceed: Openly, so that all points of view on patient benefits can be heard; soundly, so that the best evidence on all factors, including cost-effectiveness, can be utilized in planning decisions; efficiently, so that patients and providers can promptly benefit from cost-effective facilities, services, and products.

A great deal of talk these days assumes that technology is a part of cost and quality problems, not part of their solution. We believe, on the contrary, that it is only through innovation, in products, facilities, services, management, that patients will truly benefit from a system that achieves the best care at the most reasonable price. In order to assure that the planning system encourages the appropriate utilization of technology, whether they be CT scanners or other products, we recommend that the planning law be amended in the following ways:

One: To include, as a factor to be taken into account in developing national planning guidelines and in reviewing proposed health systems changes, the affirmative responsibility of the health plan-
ning system to assure the prompt and reasonable utilization of cost-effective medical technology. For example, in section 1502 we would recommend a 13 national health priority stating this responsibility.

Two: To provide special criteria for research institutions as they make equipment purchases or capital expenditures.

Three: To revise the definition of "indirect providers" for purposes of determining representation on HSA governing bodies by making clear that makers of all kinds of medical products are eligible to participate.

Four: To require that one to two members of the National Advisory Council on Health Planning and Resources be representative of indirect providers knowledgeable about the cost-effectiveness of medical technology.

Five: To reduce the obstacles to replacing obsolete or less cost-beneficial equipment.

These are our suggested additions to your amendments.

Next I wish to briefly comment on certain amendments embodied in H.R. 10460 which may impose too many new responsibilities on the health planning process at this time.

As you know, the health planning system created in 1974 through the efforts of this subcommittee, has a sound basic idea: to take, from a local perspective, a comprehensive look at the needs for health facilities and services. This basic idea is just being implemented. For example, as the HEW testimony this week reported, only 9 of the 205 health systems agencies are fully certified. Therefore, although hopes are high, the HSA system is in its infancy. What it most needs is a stable environment to grow.

We fear that certain amendments proposed by your bill, H.R. 10460, and suggested by the administration will prematurely encumber the planning system with unreasonable new responsibilities and layers of review. Now, when the HSA's and State level bodies are being started up, is not the time to add so many more demands on their capacities and resources.

Specifically, we propose the following:

One: The authority embodied in H.R. 10460 should be extended for 6 years, instead of the 4 years proposed in the bill. For at least the first 2 years, there should be a simple extension of existing authority with needed technical changes. In the later years, there could be extension of authority contingent upon a congressional review and finding that that system was ready for its new responsibilities.

Two: Authority to provide certificate-of-need and equipment review for noninstitutional health services should be removed or drastically reduced. Whatever the merits of these proposals may be, it is simply too soon to extend the planning authority so dramatically. If problems of abuse or avoidance of existing statutory provisions exist, we suggest that they be dealt with directly, rather than by blanketing the entire planning system with new responsibility that goes far beyond the abuse. We note that the Clinical Laboratory Improvement Act, recently approved by this subcommittee, provides an exclusion for individuals and small groups of practitioners; perhaps an analogous provision could be considered here.
Three: Similarly, appropriateness review, while recognized to exist in the current law, is provided added authority in H.R. 10460. We believe that this new authority simply represents too burden-some a task to levy on the States and HSA’s at this time.

I have mentioned CT scanners in passing, but let me take a moment to use them as an illustration of where things can go wrong with the planning process.

First, let me say that the medical efficacy of scanning is not seriously being questioned by anyone at this time. To illustrate, even though last year’s Institute of Medicine study suggested certain additional clinical trials, it did not question the basic medical importance and usefulness of scanning. Instead, the issue has focused on effective utilization and the cost consequences.

However, the total cost of CT scanning in 1977 and the cost of scanning in 1980 have been estimated to be roughly equal to the cost of medical and surgical procedures it replaces. In other words, CT scanning has not significantly changed the cost of medical diagnosis when appropriately used and has the potential to reduce costs in the future. Specifically it is estimated that the cost of CT scanning in 1977 is approximately equivalent to the conventional diagnostic procedures it replaces, in that the total cost of diagnosing of these suspected abnormalities for which CT is considered medically appropriate is estimated at approximately $3.2 billion in 1977. And this cost could decline slightly in 1980 despite the fact that 4 million CT procedures will be done [2,500,000 or 267 percent more procedures than in 1977]. The estimated cost of diagnosing these disorders if CT were not available would be about the same—$3 billion in both 1977 and 1980. Among key assumptions, on which the cost comparison for 1980 is based, is that by then CT will bear out its promise of substituting in part for such procedures as X-ray, pneumoencephalography, angiography, nuclear medicine, and exploratory surgery; this already is happening in many major medical centers.

It is worth emphasizing, too, that these estimates do not assign any value to certain real gains to patient care provided by CT, such as increased ease and accuracy of diagnosing, improved patient comfort, reduced risk of mortality and morbidity, and other qualitative advantages of CT scanning. Obviously, these kinds of gains, while difficult to quantify, are among the most important health care benefits that medical technology can hope to achieve.

With this kind of record, one would think that prompt introduction of a reasonable number of CT scanners, properly dispersed, would be in fact an affirmative goal of the planning process. Yet the motivating factor in much of the CT debate seems to be dealing with a runaway horse. The common belief about CT scanners is that they are being bought by the plane load, willy-nilly. On the contrary, certificates of need approvals and orders for scanners have dropped drastically.

I would like to illustrate. Industry surveys of planning agencies indicate a clear trend. For example, our information indicates that orders approximated 350 units in the first half of 1976 and 250 units in the second half. That number had dropped in the first half of
1977 to approximately 150 units and in the second half the estimate is that it will be about 90 units. In this year, 1978, in the first half we estimate the number of units will be between 50 and 70 and by the second half will have gone to the 30 or 40 range.

Finally, to talk for a moment about 1979, in the first half of 1979 it looks as though the number will further drop to the 20 to 30 range.

Contrary to popular belief, private purchases of scanners are minimal, and have not risen to fill in the decrease in CON approvals. In short, the planning process has already brought scanner placements to a crawl compared to the pace 18 months ago. In view of the efficacy and favorable cost impact of scanning, this is not simply a reaction to a problem, it is an over-reaction, spurred by fears of potential abuse which over-ran a thoughtful appraisal of both the total costs and total benefits of scanning.

The HEW guidelines proposed in September and republished recently will write this over-reaction into Federal regulations. Contrary to published reports, the January CT scanner guideline is not better from our point of view; it is worse. The effect of the numerical limits with respect to patient procedures and the new definition of patient procedure will severely curtail further dispersion of this cost-beneficial product. This is not in the interest of the best health care.

This illustration is not cited for the purpose of condemning out of hand the entire CON, HSA or guideline-writing process. Instead, it is offered to support our view that the entire planning process must from the start be affirmatively focused on encouraging the introduction of technology which is cost-effective. This requires different guidance for CON review and HSA’s, as we have recommended. It requires that the planning process get its feet on the ground and develop the capacity to make sound decisions before it shoulders new responsibilities.

We appreciate the opportunity to be here this morning, and we will be pleased to answer any questions you may have.

Mr. Rogers. Thank you very much for your suggestions, which the committee will look at carefully.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

You know, we have heard more about computerized axial tomography in the past few weeks than I have ever heard about any sort of instrument whatever. CAT scanners—I am afraid someone is going to think we are saying cat skinners, we have skun more cats in the past few weeks than I have ever heard skun.

There are so many other things in addition to the CAT scanners that are involved.

Actually you use CAT scanners for pneumoencephalographies is that not true?

Mr. BUZZELL. Yes.

Mr. CARTER. Otherwise how would you do this if you want an encephalography?

Mr. BUZZELL. I cannot answer that question.

Mr. McCUNE. You have obviously just narrowed your options. You would have to go to surgery.
Mr. Carter. Yes, through the base of a scull you could go and then underneath and so forth. It is a rather difficult procedure.

You use scanners for angiography. So that we know what that is, let's just explain that procedure.

Mr. McCune. That is injection of enhancement dye that allows better contrast in your diagnostic results.

Mr. Carter. It shows us the size or interlining of arteries, is that correct, of blood vessels?

Mr. McCune. Yes.

Mr. Carter. Instead of that, without a CAT scanner we would have to use a catheter and go in. This saves that; is that true?

Mr. McCune. Yes, sir. I am not a physician, but in my personal opinion I would say it would certainly be less painful.

Mr. Carter. Did you develop the CAT scanner, the computerized axial tomograph?

Mr. McCune. One of our mutual companies that belongs to both organizations, EMI of England, was the principal developer of the computer axial tomographic scanner.

Mr. Carter. It really offers a great deal of assistance in diagnosing different cases. In nuclear medicine, for instance. Furthermore, many of us are becoming a little bit afraid as time goes on that because of the injection of radioactive materials into the bloodstream, it is thought now to cause forms of cancer. This would replace that and also exploratory surgery.

What is the cost of the average scanner? Let's leave off the word "CAT". That does not sound like medicine at all.

Mr. McCune. An average would be difficult because there are several configurations. You have a straight head scanner, a body and head scanner or straight body scanner. For a combination system, an average figure I think you are looking at $500,000. In the state of the art, the learning curve on head scanners, is bringing the unit cost down, they are now available in the upper $90,000 to $140,000. The free market always works for a downward price.

Mr. Carter. What about a deep therapy X-ray machine, what is the cost of that?

Mr. McCune. Deep therapy?

Mr. Carter. Yes; no one has mentioned that.

Mr. McCune. Again, as a physician you know you can get the Ford or the Cadillac.

I would say probably an average of $250,000.

Mr. Carter. No one has mentioned that although there are many more of them around, I think

What about a cobalt machine, what is the cost of a cobalt machine?

No one has bandied that about either.

Mr. McCune. The Cobalt 60 machine when first introduced in the market several years ago—it is now being phased out because of new machines, but the Cobalt 60, I believe, came into the market at about $175,000 to $200,000.

Mr. Carter. What about the lineal accelerator?

Mr. McCune. I believe you are looking at something higher, but that is due to the state of the art progress and the patient improvement.
Mr. Carter. There are many other things besides scanners to talk about. I think we should talk about some of the other things. We have skinned too many cats already.

Do you feel that a private physician with a large practice or a group of physicians who deal solely with patients who do not receive Federal largesse should be permitted to buy a scanner if they so desire?

Mr. Buzzell. Yes.

Mr. Carter. Or linear accelerators?

Mr. Buzzell. Yes.

Mr. Carter. Or a coulter machine, a blood counter?

Mr. McCune. Yes, sir.

Mr. Carter. I tend to agree with you on that. I think you would agree we must use facilities as cost effectively as possible, and as long as it is not at the expense of the patient. We have to consider the patient.

Of course, this legislation, when passing this we could hurt an industry, practically destroy it. I want you to survive and flourish, but certainly I would hope it would not raise the level of health care costs all over the country.

Thank you, Mr. Chairman.

Mr. Rogers. Thank you.

What is the exposure of radiation to the patient when one uses a CAT scanner?

Mr. McCune. It would be relative to the type of procedure being used.

Mr. Rogers. A head scanner?

Mr. McCune. I think probably the same level as a basic scull X-ray, 1½ rads perhaps. Again, I am not a radiologist.

I would say you are in the same ball park as your regular X-ray equipment or less. Your earlier models were slower, but we are down to 1- and 2-second scans.

Mr. Rogers. What about a body scanner?

Mr. McCune. It is hard to be specific because, it depends on the organ, the pancreas might require 4 to 6 or more slices. The slices are what is involved. It is like a fibrosopic examination, you will get more rads in that procedure than in a chest X-ray. It is hard to be specific, but I think it would stand up in terms of what presently is being done or be better.

Mr. Rogers. Have any studies been done on the effects of radiation from the scanner?

Mr. McCune. Yes, sir; we are working very closely with the Bureau of Radiological Health and they are working closely to see that we work for improvements and I think improvements are there.

Mr. Rogers. Would you let us have any studies that have been done for the record?

Mr. McCune. I can't speak for the Bureau of Radiological Health.

Mr. Rogers. We will contact them.

Mr. Carter. You express this in terms of rads?

Mr. McCune. Yes, sir.
Mr. Carter. I understand—I heard this from McCormack, some-
one from Washington—if one walks through Union Station his ex-
posure to X-radiation there is 500 milligrams.

Thank you, Mr. Chairman.

Mr. Rogers. That would be five-tenths of a rem?

Mr. McCune. Yes; your atmospheric scatter is getting quite
serious.

Mr. Rogers. What large capital expenditures in technology could
you point to that truly are labor or cost saving?

Mr. Buzzell. A major sterilization system for a hospital replacing
the old enclave unit sterilizers and major laundry systems are
examples.

Mr. Rogers. Would you let us have some figures on that? I think
that would be helpful.

Mr. Buzzell. Yes, sir.

Mr. Rogers. As I noticed, Mr. Buzzell, in your testimony you say
already they have sold some 950 scanners in this country.

Mr. Buzzell. I made reference to the approvals on a year-by-year
basis.

Mr. Rogers. In other words, they have been approved but not that
many actually sold?

Mr. Buzzell. They are either on order or in place in the aggregate.

Mr. Rogers. Is it anticipated all the orders will be filled?

Mr. Buzzell. I think most of them will be filled, probably all of
them because they do represent certificate-of-need approvals. They
have been through the planning process.

Mr. McCune. I think today a manufacturer would not consider he
has a contract until he has the certificate-of-need approval. That is
why we support the procedure.

Mr. Rogers. Has there been any difficulty getting CAT scanners
as far as certificate-of-need is concerned?

Mr. McCune. Yes; I think that is the point we are trying to make;
that is, your planning system that is out there has certainly focused
on the scanner and the approval process is a very thoughtful and
very thorough process. Our point is that it is working and you can
see by the data I gave you that in fact the certificate-of-need that
is required, is one that goes through very careful scrutiny now, and
there certainly has been difficulties on the part of individual hospi-
tals securing scanners.

Mr. Rogers. Has that been a supply problem or a certificate-of-
need problem?

Mr. Buzzell. First of all, the certificate-of-need process is dictat-
ing the placement of scanners into a facility. Clearly there has been
lag time in the supply, I would ask Bob McCune, but I believe the
demand is being met. It is more a question of thorough review by
the planning people. The point we wanted to make is that your
planning system in terms of this one piece of equipment, is certainly
working.

Mr. McCune. I think that is a fair statement, as these CAT scan-
ner guidelines are promulgated, I think the door will come down
and regardless of how many sets of needs you have, there won't be
any more.