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INTRODUCTION

The national health planning program increasingly has come under attack by the current Administration and others seeking its repeal. The program created a regulatory process involving local, regional, state, and federal agencies in the development and implementation of plans and policies designed to improve the accessibility and quality of health care, and to control health care costs.

The American College of Physicians believes that it would be inappropriate to eliminate the existing health planning process without the provision for effective means for improving the accessibility and quality of health care in the United States. Instead, the College supports revising the process to more effectively provide a framework fostering state and local flexibility and involvement.

SUMMARY OF ACP POSITIONS

1. Health planning is needed to address problems of access and quality of health care. It should be a process for deciding, at state and local levels, what services are appropriate and will be encouraged in each community. Promotion of a healthful environment and development of a health care system in which appropriate quality health care is accessible to all people must remain a national priority.
2. By encouraging the provision of appropriate services, health planning can help ~~restrain increases in costs~~. A national program should be maintained to provide a structural framework for effective health planning and appropriate allocation of health resources at the state and local level.
3. The National Health Planning and Resources Development Act (P.L. 93-641, as amended) should be revised to ensure that access to appropriate quality medical care is the major emphasis of health planning and that state and local communities have sufficient flexibility and means to develop plans to meet local needs.

RATIONALE

1. POSITION

Health planning is needed to address problems of access and quality of health care. It should be a process for deciding, at state and local levels, what services are appropriate and will be encouraged in each community. Promotion of a healthful environment and development of a health care system in which appropriate quality health care is accessible to all people must remain a national priority.

RATIONALE

The health care delivery system is a dynamic and complex system which has developed in response to public health needs; to community, government, and private interests; and to a variety of other factors. Despite vast expenditures, the system has not always been responsive to the health care needs of all segments of the population, such as low income persons, minorities, the elderly, the handicapped, and other groups. Health care facilities and health manpower have been geographically distributed in ways which often have appeared to be haphazard and which have created an abundance of medical care services in some areas and shortages in others.

Health planning has developed as a means of providing a coordinated approach to more effectively allocate community health care resources. It provides a process in which needs are identified, national and local priorities are established, and plans are organized and implemented to address these problems. Health planning provides a framework in which new developments in the health care field involving technology, financing, training, and the delivery of care can be evaluated objectively based on community needs.

Federal health planning legislation since the Hill-Burton Act of 1946 has sought to improve the nation's health care system and has recognized this system as a national resource. The Comprehensive Health Planning Program (CHPP) in 1966 and the National Health Planning and Resources Development Act of 1974 (P.L. 93-641), as amended in 1979, have affirmed the national commitment to promoting a healthful environment and assuring that appropriate quality care is accessible and affordable.

Establishment of community goals and objectives for meeting identified needs becomes increasingly important as national efforts are made to curtail government spending. Limitations of public financial resources available for the construction and support of health care facilities further increase the need for health planning.

The American College of Physicians, an organization dedicated to maintaining high standards in medical practice and to fostering measures for the prevention of disease and for improving public health, believes that the goals of health planning should remain a national priority.

2. POSITION

By encouraging the provision of appropriate services, health planning can help restrain increases in costs. A national program should be maintained to provide a structural framework for effective health planning and appropriate allocation of health resources at the state and local level.

RATIONALE

Haphazard development of the health care delivery system is extremely expensive and fuels escalation of health care costs. Supporters of the national health planning program claim that the program has reviewed \$5-6 billion worth of projects resulting in disapprovals of approximately \$1 billion of unneeded projects. The mere existence of the program is claimed to have discouraged an additional \$1 billion worth of unneeded construction. However, construction costs represent only a fraction of the total costs generated by health care facilities. Unrestrained construction of health care facilities would create pressures for greater utilization of services and would cause health care costs to rise.

Because the public has a substantial personal and financial interest in maintaining an effective and efficient health care system, because the availability of health care services in one facility may influence their availability and cost in other facilities, and because substantial public expenditures often are involved, it is essential that a process be available in which the need for health facilities and services is determined by the people who are to be served. The College supports maintenance of a planning process to discourage the provision of unneeded, duplicative, or inefficient facilities.

Many of the priorities established in national health planning legislation have not been met throughout the country, and the need remains for a mechanism which facilitates coordinated planning among federal, state, and local agencies. The College wishes to emphasize the continued need for planning efforts to develop multi-institutional arrangements for the sharing of support services; to foster the development of the capacity of health service institutions to provide various levels of care on a geographically integrated basis; to promote activities for the prevention of disease, including studies of nutritional and environmental factors affecting health, and the provision of preventive health services; to identify and discontinue duplicative or unneeded services; and to promote greater efficiency.

The College, however, has observed that the existing national health planning program has been targeted almost exclusively toward restraining cost, rather than also toward improving the quality of and access to health care. Control of costs is an important objective, but the primary goal of health planning should be to more rationally allocate limited resources for the delivery of high quality health care.

Federal guidance should continue to be provided to state and local planning agencies in the form of information for developing and implementing health plans. The federal role in health planning must include collecting and disseminating statistical and technical information related to health planning and resource development. State and local health planners should be provided with advisory federal standards for such services as general hospital bed supply, suggested targets for hospital occupancy rates, requirements for neonatal special care units, minimum case loads recommended for justification of cardiac catheterization units, and service needs for end-stage renal disease. The federal role should be one of guidance and support so that rational planning and resource allocation decisions can be made at the state and local levels.

Determination of local health care needs and development of appropriate goals and objectives can best be accomplished through a planning process involving active community participation. However, community health planning should not be a sham. To be effective it must have adequate technical and financial support; plans should be coordinated with state and regional planning efforts; and there must be a means for assuring adherence to agreed upon plans.

Thus, the College favors a federal role in health planning that (1) provides information and a framework for consistent health planning on a national scale through coordinated state and local planning efforts, and (2) provides the technical and financial resources needed to maintain viable planning efforts at the state and local levels.

3. POSITION

The National Health Planning and Resources Development Act (P.L. 93-641, as amended) should be revised to ensure that access to appropriate quality medical care is the major emphasis of health planning and that state and local communities have sufficient flexibility and means to develop plans to meet local needs.

RATIONALE

Previous efforts to determine or achieve national goals through health planning at state and local levels were largely unsuccessful due to differences in local programs, lack of funding, overlapping of responsibilities and efforts, and inadequate staffing or authority. No mechanism existed for determining national health care needs or

for allocating national resources to improve the health care delivery system. Instead, there were many disjointed and often conflicting health planning efforts at various levels of government. Federal financial support for health planning was provided through a variety of programs, often with differing purposes and objectives. Although many local and regional health planning agencies were successful in identifying and addressing local health care needs, there was no coordinated and systematic health planning on a national basis.

Consequently, Congress established the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) which was designed to deal with planning, resource allocation and regulation in the field of health through a single set of organizational structures at the state and regional levels. It attempted to draw upon the successful planning experiences of many regional medical programs and comprehensive health planning agencies in addressing local needs. Much of the personnel, organization and knowledge from these earlier programs provided the foundation for the restructured national health planning effort.

The structure that evolved provided for the coordination of planning activities on a national basis, and encouraged the involvement of consumers and providers of health care at the local level. Under the program, plans have been developed and implemented to extend health care services to underserved populations in urban and rural areas, promote public health education, increase preventive health services, develop alternative delivery systems, improve services to such groups as the elderly and disabled, and facilitate multi-institutional health care arrangements. Efforts have also been organized through the planning process to institute immunization programs, achieve better utilization of hospital and long term care facilities, encourage the delivery of services for the mentally ill and retarded, develop facilities for the treatment of alcoholism and drug abuse, reduce environmental health hazards, and to address many other important health care needs.

The American College of Physicians believes that there continues to be a need for national health planning. The existing national health planning program, however, has concentrated too much on containing cost and not enough on improving access to appropriate quality health care. The College favors returning the initiative for determination of health care needs and development of the means to address these needs to state, regional, and local levels. The College further favors elimination of unnecessary, duplicative and excessively time-consuming paperwork and regulations required with the current planning process. The College also supports discontinuation of federal requirements for appropriateness reviews and reviews of proposed use of federal funds (PUFF). Thus, the American College of Physicians does not support

total repeal of the National Health Planning and Resources Development Act, but believes that the Act should be further revised to build upon the foundations that have already evolved.

BACKGROUND

Federal health planning activities are generally considered to have begun in 1946 with enactment of the Hospital Survey and Construction Act (P.L. 79-725), better known as the Hill-Burton Act. This law authorized federal aid to states for the construction of hospital facilities. It created State Health Planning Councils and tied allocation of federal financial resources to state plans under Section 314(a) of the Public Health Service (PHS) Act.

Under provisions of Section 318 of the PHS Act, which were passed in 1961, federal financial assistance was also provided to local hospital planning agencies that worked with the states in Hill-Burton planning activities. Further federal efforts to stimulate local health planning and to encourage consumer and provider participation resulted in the passage of the Comprehensive Health Planning and Public Health Services Amendments of 1966 (P.L. 89-749).

These amendments established Section 314(b), "The Partnership for Health Act," which authorized federal assistance for area-wide comprehensive health planning. More than 200 "b" agencies were eventually established throughout the country. These agencies developed plans for the organization and operation of community health programs. They had responsibility for "review and comment" related to a variety of uses of federal funds, but they lacked the power necessary to implement their plans. Planning by the 314(b) agencies was not backed by any regulatory or quasi-regulatory authority.

Enactment of Titles XVIII and XIX of the Social Security Act (Medicare and Medicaid) in 1965 and 1967 focused national attention on problems within the health field and vastly increased federal expenditures for health care. Also in 1965, following recommendations of the Report of the President's Commission on Heart Disease, Cancer and Stroke (December, 1964), Congress enacted legislation (P.L. 89-239, The Health Disease, Cancer and Stroke Amendments to the Social Security Act) creating Regional Medical Programs (RMPs).

The RMPs originally were intended to foster the development of regional centers for treating victims of heart disease, cancer, and stroke. They were concerned primarily with increasing and sharing knowledge about technological developments in medical care.

By 1974 more than 50 RMPs had been established across the country; some were multi-state, some were statewide, and others served regions within a state. Program emphasis for the RMPs gradually shifted from specific diseases to primary care, regionalization of health care resources, and improved use of health manpower in underserved areas. Planning and priority setting in the RMPs were responsibilities of regional advisory groups; however, there were few ties to the other planning mechanisms that had developed for the allocation of financial resources.

Another federal planning effort had been launched in 1971 under the Experimental Health Services Delivery Systems Act. This program provided funding for community demonstrations which developed independent management corporations for health services at the community level. These agencies performed a number of functions similar to those of "b" agencies and RMPs. Their primary emphasis was on the collection of data and the establishment of a management information system.

Meanwhile, increasing concerns over the cost of Medicare and Medicaid generated greater pressure for cost control. Congress responded in 1972 by passing major amendments to the Social Security Act (P.L. 92-603). A new Section 1122 of the Act required federal approval of all capital expenditures and services that received Medicare or Medicaid reimbursement. To fulfill the requirements of the amendments, areawide Comprehensive Health Planning Councils sought further legislation to increase their authority from "review and comment" to "review and approval."

Thus, by 1974, a complex structure existed under a variety of federally sponsored programs for health planning, health resource allocation, and regulation of health care.

Planning under the Hill-Burton program flowed through state agencies including Comprehensive Planning Agencies [314(a)], State Hill-Burton Agencies, and agencies designated under Section 1122. At the local level there were over 200 areawide Comprehensive Health Planning Agencies [314(b)]. There were more than 50 regional medical programs; there were experimental health services delivery systems; and there were the local community institutions and agencies.

In addition to these overlapping and often duplicative arrangements, there were also separate planning agencies which had been created for categorical health related program planning. Agencies for drug abuse planning, alcoholism planning, and public health planning had arisen in response to federal requirements for the development of plans as a condition for release and expenditure of categorical federal financial support.

Recognizing that there was a continued need for health planning, but that the existing planning structure was overly complex, often duplicative and generally ineffective, Congress enacted the Health Planning and Resources Development Act of 1974 (P.L. 93-641). Signed into law in January 1975, the Act attempted to replace the previous system with a coordinated, structured approach. The Act attempted to incorporate the successful features of previous planning efforts, to eliminate duplication of efforts, and to strengthen the planning process.

P.L. 93-641 redefined the goals and functions of the health planning and development process. The Act originally established the following ten national priorities:

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

2. The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).
3. The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.
4. The training and increased utilization of physician assistants, especially nurse clinicians.
5. The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.
6. The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under Part B of Title XI of the Social Security Act.
7. The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.
8. The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.
9. The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.
10. The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

Amendments to the Act in 1979 (P.L. 96-79) added seven new priorities. These amendments also added provision for development and use of cost saving technology. The additional priorities were:

11. The promotion of an effective energy conservation and fuel efficiency program for health service institutions to reduce the rate of growth of demand for energy.
12. The identification and discontinuance of duplicative or unneeded services and facilities.
13. The adoption of policies which will (A) contain the rapidly rising costs of health care delivery, (B) insure more appropriate

use of health care services, and (C) promote greater efficiency in the health care delivery system.

14. The elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of the quality of care provided those with mental health problems for whom institutional care is appropriate.
15. Assurance of access to community mental health centers and other mental health care providers for needed mental health services to emphasize the provision of outpatient as a preferable alternative to inpatient mental health services.
16. The promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and the maintenance of health.
17. The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, ...to advance the purposes of quality assurance, cost effectiveness, and access.

To implement the national health planning law, Congress devised a framework to incorporate local, regional, state, and federal input into the planning process. Community councils and local agencies remained as advisory bodies designed to assure consumer and provider participation. Regional involvement was assured through the designation of health service areas according to geographic, population, and economic factors as well as through consideration of the availability of health care resources.

The law provides for designation of a Health Systems Agency (HSA) for each health service area. Some 213 HSAs have been established. The HSAs are responsible for preparing and implementing plans designed to improve the health of residents in their areas; to increase the accessibility, acceptability, continuity and quality of health services in their area; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources.

The law also authorizes State Health Planning and Development Agencies (SHPDAs). There are 57 State Agencies responsible for conducting state health planning activities and for implementing those parts of the State Health Plan and the plans of the Health Systems Agencies, which relate to the government of the state. The SHPDA integrates the health plans of the Health Systems Agencies into a preliminary State Health Plan and serves as the designated planning agency for those states which participate in Section 1122 of the Social Security Act. The State Agencies also administer state certificate of need laws and conduct appropriateness reviews of existing facilities.

Final responsibility for approval of State Health Plans rests with Statewide Health Coordinating Councils (SHCCs). These agencies, which are comprised of consumers and representatives from the Health Systems Agencies, prepare the

State Health Plan, review the budgets of the HSAs, and advise the State Agency on the performance of its functions.

The Secretary of the federal Department of Health and Human Services has responsibility for administration of the health planning program. The Department of Health and Human Services issues guidelines on national health planning policy; provides priorities for planning goals; designates health planning agencies under the Act; and provides guidelines for State Health Plans, Health Systems Plans, and Annual Implementation Plans.

P.L. 93-641 gave planning agencies authority for four types of reviews: certificate-of-need, Section 1122, appropriateness reviews, and reviews of proposed uses of certain federal health funds.

Certificate-of-need programs require that capital expenditures, major medical equipment purchases and new or revised institutional health services must be justified based on community needs. Health Systems Agencies conduct reviews and then forward their recommendations to the State Health Planning and Development Agency for final review and the issuance or denial of certificate-of-need. Reimbursement under Medicare and Medicaid is not authorized in facilities or for services lacking certificate of need approval.

Amendments contained in the Omnibus Reconciliation Act of 1981 raised the thresholds for certificate-of-need review from \$150,000 to \$600,000 for capital expenditures, from \$150,000 to \$400,000 for acquisition of major medical equipment, and from \$75,000 to \$250,000 for new institutional services.

Reviews under Section 1122 of the Social Security Act are conducted for capital expenditures exceeding \$100,000 which increase or decrease a facility's bed capacity or add or terminate a clinically related service. Section 1122 review is required for reimbursement under the Social Security Act; it covers certain capital expenditures not in federal certificate-of-need requirements.

Appropriateness reviews are perhaps the most controversial in the health planning program. The law contains provisions for state and local agencies to review the appropriateness of existing institutional and home health services. Existing services are reviewed on the basis of need, quality, accessibility and availability, financial viability, and cost effectiveness.

Amendments to the health planning program in 1979 established the fourth type of review: for Proposed Uses of Federal Funds (PUFF). These reviews were intended to ensure that federal health funds are spent in a manner consistent with local needs as identified in local health plans. PUFF reviews were required for federal funds available under the Public Health Service Act; the Community Mental Health Centers Act; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act; and the Drug Abuse Prevention, Treatment and Rehabilitation Act.

The Health Planning and Resources Development Act (P.L. 93-641) was amended extensively in 1979. In addition to extending the authorities established under the Act for an additional three years, the amendments further strengthened the regulatory functions of the program. The Secretary of HHS was directed to issue guidelines by regulation concerning national health policy, and the states were given deadlines for adopting certificate-of-need laws in compliance with federal guidelines. The amendments established seven additional national priorities (discussed previously). PUFF reviews were also created and emphasis was given to fostering competition.

Reaction to enforcement of the 1979 amendments, as well as changes in the political climate brought the national health planning program under increasing attack. The Reagan Administration has announced its intent to eliminate the program and has submitted budget requests for 1981-1984 accordingly.

Provisions adopted in the Omnibus Reconciliation Act of 1981 which affect health planning include the following, in addition to the changes in the certificate-of-need thresholds discussed earlier:

- o authorization of the program in FY 1982 was set at \$102 million (\$145 million had been appropriated in 1981).
- o HSA requirements for Appropriateness Review and reviews of Proposed Use of Federal Funds may be waived by the Secretary of HHS upon request, if it is determined that the HSA lacks adequate federal funding to support such activities.
- o The deadline for state compliance with certificate-of-need laws was extended for one additional year.
- o Governors may apply to eliminate HSAs if the purposes of the Act can be accomplished without the HSA.
- o Health insurers are permitted to contribute to the support of HSAs.

The Administration continues to seek repeal of the program. Representatives Richard Shelby (D-AL) and Phil Gramm (D-TX) have co-sponsored legislation (HR 3666) for repeal of the program by October 1, 1983. Existing authorizations expire on September 30, 1982. Congressional hearings on the future of health planning can be expected in early 1982.