M I N U T E S

SPECIAL COMMITTEE ON HEALTH AND HUMAN RESOURCES

November 12, 1975

Members Present

Representative Richard B. Walker, Chairman
Senator Elwaine F. Pomeroy, Vice-Chairman
Senator John F. Vermillion
Representative J. Santford Duncan
Representative Sharon Hess
Representative Marvin L. Littlejohn
Representative Norman E. Justice
Representative Anita Niles

Staff Present

Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes Office
Myrta Anderson, Legislative Research Department

Others

Stewart Entz, Kansas Association of Homes for the Aging, Topeka, Kansas
Dwight F. Metzler, Department of Health and Environment, Topeka, Kansas
Ronald E. Schmidt, Department of Health and Environment, Topeka, Kansas
Mary I. Browne, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Ira Dennis Hawver, Kansas Department of Health and Environment, Topeka, Kansas
Gary Caruthers, Kansas Medical Society, Topeka, Kansas

The meeting was called to order at 9:35 a.m. by the chairman, Representative Richard B. Walker.

A motion was made and seconded to approve the minutes of the November 3, 1975 meeting. Motion carried.

Proposal No. 23 - P.L. 93-641

The chairman noted the input from various groups and called attention to the written statements which were distributed. (Attachments 1 through 3.)

Dwight F. Metzler, Secretary, Department of Health and Environment, commended the Committee on its work and noted that their recommendations do not change the philosophy adopted by the Committee. The Department's recommendations are aimed at relating the federal law as they understand it to specific problems in Kansas. Secretary Metzler presented a written statement listing their recommendations and the rationale for them. (Attachment 4.)

In discussion of the recommendations, it was noted the Committee had set the SHCC membership at 27 because they had counted the VA representative as part of the 40 percent. Mr. Metzler noted there is only a difference of one member. He stated they are concerned about a group of 28 working well but feel the state needs some representatives other than those required by the federal law.

Mr. Metzler expressed concern over setting a threshold figure in the certificate of need legislation, noting the five percent or $150,000, whichever is lower, was a recommendation of the HEW regional office. He suggested giving some flexibility to the state agency to set the figure.

Staff referred to the recommendation regarding the definition of health facilities (attachment 4) asking if the Department is recommending the coverage of the present law be reduced. Mr. Metzler stated they were for the reasons given. Also, it seemed the present definition could be misinterpreted. He will check to see if this has happened. In answer to a question, he stated they had considered the definition of new institutional services in the federal act before making this recommendation.

In answer to questions relating to their recommendation that there be no application fee, Mr. Metzler stated the amount collected would not be enough to make any real difference.

Mr. Metzler stated their recommendation regarding Section 26 of the certificate of need bill was a question because he felt they had not done enough staff work to make a specific recommendation. He felt that if in the planning process it is decided additions or changes at a state facility are not needed, the body making the final decision regarding expenditures at state facilities can take this into account without going through the certificate of need process.

In answer to a question, Mr. Metzler stated he felt the certificate of need bill needed to go to the legislature as soon as possible. The issues and how they apply to Kansas are known; there will not be enough information from other states in one year for us to benefit by their mistakes; it is better for Kansans to know what the rules will be as soon as possible; if changes are indicated in a year or two, they can be made then.

Not including all types of health facilities in the certificate of need legislation was questioned. Mr. Metzler stated they do not feel planning will have enough impact on some types of activity to make any difference. They could be added later if this was not true. Also, the Department has to decide how and where to use their limited staff to have the most impact. In answer to a question, he noted the estimated $25,000 from fees would not allow much more staff. He expressed the feeling that fees should be high enough to cover some of the costs or they should be dropped, noting this was a policy question for the legislature. He mentioned that the $2.00 for child care facilities set in 1919 may not even cover postage costs now.

It was pointed out that a mental health center deciding to have inpatient beds would have an impact on other facilities such as a hospital wanting to add psychiatric beds. Staff referred to sections of the federal act and the report of the Congressional Committee relating to fees and facilities subject to review. Mr. Metzler stated the Department would take another look at the type of facilities to be included and would have a more refined recommendation to the staff.

A recommendation presented to the Committee earlier by Dr. Weiss was referred to. Mr. Metzler noted that since that time the Department had had further discussion with the HEW regional office and they feel the federal regulations will basically repeat sections of the federal act. He noted that although there are no sanctions if action is delayed, it will be advantageous to Kansas to take action now. However, whether action is taken now and how technical changes should be handled are policy questions for the Committee.

Mr. Metzler reviewed the status of each HSA noting they will all be functioning soon after January 1976 at the earliest or soon after July 1976 at the latest.

The Kansas Association of Osteopathic Medicine presented a written statement. (Attachment 1.) In answer to questions, Mary Browne stated they want to be considered separately so the reviewing group will know that osteopathic hospitals offer different services; when their hospitals are crowded, osteopaths do not demand their patients be put in other hospitals because they prefer to work with the staff they are used to working with and because of the treatment they get in other hospitals; the hospital in Wichita is a training hospital and some of the others are used for preceptorship training. Osteopathic hospitals are licensed under the medical facilities licensing act as general hospitals.

The Kansas Medical Society presented a written statement. (Attachment 2.) The Chairman also referred to the written statement of the Kansas Hospital Association. (Attachment 3.)

Steward Entz, Kansas Association of Homes for the Aging, stated the threshold figure is critical in terms of expenditures required to comply with federal regulations. However, after checking with some of the homes, a $100,000 figure seems to be reasonable. They recommend the application fee be deleted since they already pay so many fees. They also recommend a pre-application procedure to get some indication of whether the proposal fits into the priorities of the state plan before going through the expense of filing a complete application.

In answer to a question about extended care homes, staff noted that in Kansas the reference is usually made to extended care beds which come under the hospital licensing act. A suggestion was made to change the definition to indicate where the reference is to acute care and where the reference is to extended care.

Certificate of Need Bill

Staff presented a redraft of the bill discussed at the last meeting. (Attachment 5.)

Staff noted that Mr. Metzler had recommended amending Section 1(a) and Section 1(b) to reduce the types of facilities included. Section 1(b) defines "health facility" in as broad a fashion as the federal act. The federal act gives two alternatives: (1) including all facilities under Sec. 1122 of the Social Security Act; and, (2) including new institutional health services which are defined as services provided through health facilities and entities. The Congressional Committee Report mentions that some states will have to add facilities to be covered, indicating their intent was a broad definition. Staff interpretation is that a broad definition will be required but HEW regulations might interpret it differently. An alternative would be to limit the definition and if the regulations require a broader definition, it could be added.

Staff noted that the Kansas Medical Society suggested an amendment specifically exempting physicians and their offices. (Attachment 2.) Since it was felt the proposed definition did not include them the suggested amendment was not adopted.

By consensus parentheses are to be inserted on page 1 before "except" in line 26, after "," in line 28, before "including" in line 29 and after "," in line 30 to clarify meaning.

Section 1(d), page 2: Health Systems Agencies can be on conditional status for more than the required one year and may be returned to conditional status if they fail to meet federal

standards. The bracketed material makes it clear that the definition includes HSA's on conditional status. A motion was made and seconded to include the bracketed material in Section 1(d). Motion carried.

Section 1(f), page 2: Mr. Metzler had recommended that SHCC be designated as the review agency. Staff stated they had written HEW regarding this section two months ago but have not received a reply. A motion was made and seconded that the SHCC be designated as the review agency. Motion carried.

Section 1(h), page 2: To comply with the terminology used in Kansas statutes, the term "health facility services" was substituted for "institutional health services" which is the term used in the federal act. The definition of the federal term was used.

Section 2, page 2: This section clarifies the present law. Staff noted provision is made later in the bill for those holding a certificate of need before the effective date of this act. A motion was made and seconded to strike "Upon the effective date of this act," page 2, line 20. Motion carried.

Section 3, page 2: Staff stated the application in this section refers to two different situations: (1) a new facility not previously licensed; (2) a facility already licensed which is expanding its facilities or services and which wants the expansion to be included under its present license.

It was noted that each licensure law for agencies under the Department of Health and Environment states in the application section that there must be a certificate of need. Staff is to check if this is included in the licensure laws for agencies under the Department of Social and Rehabilitation Services. Staff noted it would be easy to add this requirement in any specific law in which it did not appear.

Mr. Hawver, Department of Health and Environment, explained that Mr. Metzler's recommendation (Attachment 4) reflected the feeling it would be better if only one agency had the authority to issue a certificate of need. As now worded, either the state agency or the review agency could issue the certificate. A conceptual motion was made and seconded that the bill be amended in the appropriate places to indicate that the review agency's decisions are to be carried out by the state agency as recommended by Mr. Metzler. Motion carried.

By consensus staff is to delete "and" page 2, line 25, and insert in lieu thereof "which is" for clarification.

Section 4, pages 2 and 3: Staff noted this section refers to Section 7 which requires compliance with the procedure sections of the federal act which sets out four specific standards to be used in determining sufficient need. An alternative would be to spell out the four standards of the federal act and/or any others the Committee might wish to include. Concern was expressed that additional standards might be out of step with the federal regulations when they are published.

The meeting was recessed for lunch at 12:00 noon and was reconvened by the chairman at 1:30 p.m.

Section 5, page 3: Staff noted the bracketed material in lines 9 and 10 is not required by federal law. Since bed category is not a defined term in this act, it could be an administrative interpretation. One intent of the law is to be able to determine the impact changes in one facility will have on other facilities. The bracketed material seems to speak to this. A motion was made and seconded to delete the bracketed material in lines 9 and 10 on page 3.

In discussion the following points were made: a change in bed category might not require an expenditure, i.e., acute beds to isolation beds; if a change in bed category requires a large expenditure, a certificate of need should be required; a facility could change its complete bed category which would have an impact on other facilities, i.e., intermediate to skilled care or convalescent type hospital to general hospital; changing the category of the facility would require relicensure or amending the current license; for licensing purposes, a general hospital is given one license for highest type care and if beds are designated for psychiatric care or alcohol or drug treatment this is not a license change but it is a change in bed category which could have an impact on other health facilities; if there was an emergency situation, there would not be time to go through the red tape of getting a certificate of need. This section would not apply to an emergency situation. Motion carried.

Section 5(a)(4), page 3: Staff noted that Mr. Metzler had recommended the deletion of this subsection. (Attachment 4.) Mr. Hawver stated they questioned whether the Department of Health and Environment or the art of state health planning had reached the point where this type decision could be made about services. In answer to questions, staff stated this subsection does not come under the threshold provision; this applies only to services provided for or through a facility and would not include the adding on of personnel. It was noted that requiring a certificate of need for some types of services also gets into the public relations and public policy areas.

A motion was made and seconded to strike subsection 5(a)(4), lines 13 and 14, page 3. The basis for the motion was Secretary Metzler's recommendation and the fact it could lead to unnecessary burdening of the certificate of need program.

Staff noted the federal act talks about services but maybe not in the context used here. Regulations may clarify this point. Some health planning councils have been making decisions about services, i.e. which hospitals in an area should have which high cost services. Motion carried.

Staff was instructed to isolate the areas discussed above and include them in the report as areas needing further consideration.

Section 5(b)(1), page 3: Staff noted that the Kansas Hospital Association had questioned using five percent stating it would create an inequity for the small hospital. A conceptual motion was made and seconded to delete five percent as a measure of threshold.

Staff noted the bracketed material is in the law now but it appears the federal act would not require it. The Kansas Hospital Association recommended that capital expenditures relate only to clinically-related or patient care-related areas. (Attachment 3.) Staff thought 1122 defined expenditures more broadly. There would be a problem defining clinically-related services and it would seem it applies only to hospitals.

A suggestion was made to leave the law as close to what it now is as possible. By consensus the bracketed material is to be left in.

Section 5(b)(3), page 4: This section would take care of cases where there was a certified estimate below $150,000 but actual project costs exceeded $150,000 by not holding the constructing agency responsible for not having a certificate of need. This would allow them to be licensed even though they did not have a certificate of need.

Section 5(b)(4), page 4: It was suggested that perhaps this was the language needed in Section 5(a)(4) and this would take care of the problem discussed previously. Staff noted this section comes under the threshold provision and Section 5(a)(4) does not.

Section 5(b)(5), page 4: This section applies to things acquired by lease or other comparable means. In answer to a question, staff stated a facility would be required to obtain a certificate of need for any expansion financed by a gift which, if acquired by purchase, would exceed $150,000.

A question was raised as to whether the relation of this subsection to the threshold should be spelled out. Following a suggestion, consensus was to change this subsection to read as does subsection 5(b)(4) -- "A capital expenditure includes".

Section 5(b)(6), page 4: This subsection relates to changes in projects after a certificate of need is granted. A motion was made and seconded to delete subsection 5(b)(6). It was noted that a change in a project after a certificate of need is granted does change what was certified as being needed in the certificate. It was pointed out that the second sentence could relate to inflation. If the change involves a different type facility it would relate to Section 5(a). Motion carried.

Section 5(b)(7), page 5: A motion was made and seconded to delete subsection 5(b)(7). This subsection is already covered in subsection 5(b)(1) and contradicts the Committee's decision not to include land. Motion carried.

Section 5(b)(2), page 3: It was noted this subsection is also inconsistent with a previous committee decision. A motion was made and seconded to delete subsection 5(b)(2). Motion carried.

By consensus, the subsections left under section 5(b) are to be set up as subsections of Section 5(a)(3).

Section 6, page 5: Staff noted that the Kansas Hospital Association and Mr. Metzler had recommended the application fee be eliminated. (Attachments 3 and 4.) There is no fee under the present law. A motion was made and seconded to delete the application fee wherever it appears. Motion carried.

In answer to a question, staff noted they did not know where the concept of a preapplication procedure originated and they had not been able to find it in laws of other states. This concept seems to imply the state plan will be very detailed. Also whether or not an application meets with the requirements of the state plan is only one of many factors to be considered as set forth by the federal act. If adopted this concept may belong in the planning statutes rather than here. By consensus the recommendation concerning a preapplication challenge was rejected.

Section 6(c)(8) page 5: This subsection is in the present law. To the staff's knowledge there is no other place in the law that gives the Department of Health and Environment the authority to look at schematic plans.

Section 7, page 7: The public law cited in line 6 sets out the criteria to be used in reviewing applications. Staff was asked how an HSA will know whether or not the application they receive is complete. Staff noted the state agency has to send a notice the application is not complete to both the applicant and the appropriate HSA. By consensus staff is to amend Section 7 to clarify that it is the applicant who sends a copy of the application to the appropriate HSA. By consensus the following change is to be made in section 6, page 5, line 11 -- insert "and to the appropriate HSA" after "agency".

Section 8, page 7: It was suggested that 90 days for approval would be more appropriate. If the application were not complete, the state agency could have 15 days in which to send it back. The state agency would then have 90 days after the completed application was received to take action. A motion was made and seconded to delete "sixty (60)" in line 13, page 7 and to insert in lieu thereof "ninety (90)". Motion carried.

Staff was asked if there is any provision in the bill for another provider or someone from the public to register an objection to the application or to become a part of the proceedings. Staff stated that this procedure is covered in the referenced section of the public law which seems to set forth a much more detailed review than is presently required.

Section 8(c), page 7: It was noted that the bracketed material is not necessary because of other provisions in the bill. A motion was made to delete section 8(c). Motion carried.

Section 9, page 7: By consensus "sixty (60)" is to be changed to "ninety (90)" to conform with the change made in Section 8.

The feeling was expressed that an applicant's request for a hearing should be in writing. A motion was made and seconded to insert "in writing" after "requests" page 7, line 25. Motion carried.

A motion was made and seconded to make the appeal procedure open to other aggrieved parties. Staff noted that it might be difficult to define aggrieved parties. In civil procedure the term aggrieved party or party at interest is used. Since there has been a court case in this area, staff is to research this point and report their findings at the next meeting. The motion and the second were withdrawn.

Section 11, page 8: The Committee will consider modifying this section to include other health agencies as parties to the review proceedings after hearing the staff report on this point at the next meeting.

Section 12 through 23: Staff noted some policy decisions needed to be made before this part of the bill could be put in good form.

Hearings may be held by a hearing examiner and/or the state agency. The Department of Health and Environment frequently uses a hearing officer but they do not use the complicated procedure set forth in this bill.

Staff is to delete excess verbage and to streamline the procedure.

Staff, in answer to a question, stated the hearing officer can report facts and a recommendation rather than writing a decision. Consensus seemed to be to follow this procedure.

Section 24, page 13: This section exempts expenditures necessitated by catastrophe or disaster due to an act of nature or forces thereof. A motion was made and seconded to include Section 24. Motion carried.

The question of replacing a depreciable asset that just wears out was raised.

Staff noted that the recommendation of the Kansas Hospital Association that an HSA have the authority to extend a certificate of need (Attachment 3) would not seem to be consistent with the federal law.

Section 26, page 13: A motion was made and seconded to include Section 26. Motion carried.

Section 27, page 13: Under the present definition of agencies not all agencies would be licensed. This section provides for a sanction against these agencies. A motion was made and seconded to include Section 27. Motion carried.

Section 28, page 14: This section, which is optional, provides for a criminal penalty. A motion was made and seconded to delete Section 28. Motion carried.

Staff is to redraft this bill for Committee consideration at the next meeting.

Committee Report on Proposal No. 23

Staff was instructed to include a relatively complete summary of P.L. 93-641 in the report.

Next Meeting

Copies of other bills to be considered and the Committee Report on Proposal No. 22 were distributed. (Attachments 6 through 9). Staff requested the Committee report be read critically and major changes be sent to them prior to the next meeting.

The next meeting will be at 9:00 a.m. on November 26. The notice to Committee members is to emphasize that due to the workload the meeting must begin promptly at 9:00 a.m.

The meeting was adjourned.

Prepared by Emalene Correll

Approved by Committee on:

11/26/75
Date

Attachment 1

OFFICIAL POSITION OF THE AMERICAN OSTEOPATHIC ASSOCIATION ON "CERTIFICATE OF NEED" LAWS

THE AMERICAN OSTEOPATHIC ASSOCIATION RECOGNIZES THE NECESSITY OF CERTIFICATE OF NEED LEGISLATION TO REGULATE THE GROWTH OF HOSPITALS AS A MEANS OF CONTROLLING HEALTH CARE COSTS. HOWEVER, THE ASSOCIATION IS OPPOSED TO HAVING OSTEOPATHIC HOSPITALS COUNTED IN WITH ALLOPATHIC HOSPITALS WHICH OUTNUMBER OUR INSTITUTIONS BY A RATIO OF 30 TO 1. EVERYWHERE IN THE NATION OSTEOPATHIC HOSPITALS, BED TOTALS AND PHYSICIANS ARE GREATLY OUTNUMBERED BY ALLOPATHIC HOSPITALS, BED TOTALS AND M.D. PHYSICIANS.

FOR EXAMPLE, OF THE 7,123 GENERAL COMMUNITY HOSPITALS IN THE NATION, ONLY 224, OR 3.8 PERCENT ARE OSTEOPATHIC FACILITIES. FURTHER, OF THE 1,535,000 TOTAL HOSPITAL BEDS IN THE COUNTRY, ONLY 25,000, OR 1.63 PERCENT, ARE OSTEOPATHIC BEDS. OBVIOUSLY, CERTIFICATE OF NEED LAWS WERE NOT DEVELOPED BECAUSE THERE IS AN EXCESS OF OSTEOPATHIC BEDS.

THE OSTEOPATHIC PROFESSION IS A POLITICALLY AND PHILOSOPHICALLY SEPARATE AND EDUCATIONALLY INDEPENDENT SCHOOL OF MEDICAL PRACTICE REPRESENTING 14,500 D.O. PHYSICIANS. THEY COMPRISE FIVE PERCENT OF ALL PHYSICIANS IN THE U.S., BUT CARE FOR TEN PERCENT OF THE POPULATION, OR 20 MILLION PATIENTS.

MORE THAN 75 PERCENT OF ALL D.O.'S ENTER GENERAL PRACTICE. THIS PERCENTAGE IS ALMOST EXACTLY REVERSED IN THE ALLOPATHIC PROFESSION WHERE NEARLY 3/4 OF M.D.'S ENGAGE IN SPECIALTY PRACTICE. THE REASON D.O.'S TREAT SUCH A DISPROPORTIONATE RATIO OF PATIENTS IS PRECISELY BECAUSE OF THE PROFESSION'S EMPHASIS ON GENERAL PRACTICE. THE OFFICE OF EDUCATION OF HEW (PUBLIC SECTOR) AND THE NATIONAL COMMISSION ON ACCREDITATION (PRIVATE SECTOR) RECOGNIZES THE AOA AS THE OFFICIAL AND ONLY AGENCY THAT CAN ACCREDIT OSTEOPATHIC EDUCATION. THE ROTATING INTERNSHIP IS CONSIDERED THE DRIVING FORCE IN PREPARING D.O. GRADUATES TO BE FULLY COMPETENT IN PATIENT CARE AND D.O.'S TO CHOOSE GENERAL PRACTICE AS OPPOSED TO SPECIALTY PRACTICE. THIS ALSO IS THE REASON OSTEOPATHIC HOSPITALS OFTEN RUN HIGHER OCCUPANCY RATES THAN ALLOPATHIC HOSPITALS.

THE ASSOCIATION STRONGLY BELIEVES THAT AREA HEALTH PLANNING COUNCILS MUST BE MORE FLEXIBLE IN THEIR THINKING REGARDING OSTEOPATHIC HOSPITALS. THE INTENT OF CERTIFICATE OF NEED LAWS WAS TO HOLD DOWN MEDICAL CARE COSTS, NOT TO CREATE NEW PROBLEMS IN THE HEALTH CARE DELIVERY SYSTEM, BY DENYING THE DEVELOPMENT OF MEDICAL FACILITIES AND PERSONNEL ACTUALLY DEMANDED.

THE OSTEOPATHIC PROFESSION IS A MAJOR SUPPLIER OF WELL TRAINED, PRIMARY CARE PHYSICIANS. THIS SUPPLY IS THREATENED BECAUSE CERTIFICATE OF NEED LAWS DO NOT CONSIDER THE GP-ORIENTED TRAINING EMPHASIS IN OSTEOPATHIC HOSPITALS, DIFFERING HOSPITAL ACCREDITING PROCEDURES, AND THE SPECIAL NEEDS OF OSTEOPATHIC PATIENTS.

FOR EXAMPLE, THE 650 NEW D.O.'S WHO WILL GRADUATE THIS JUNE, WILL ENTER ROTATING INTERNSHIP PROGRAMS IN THE 67 AOA-APPROVED OSTEOPATHIC HOSPITALS. THESE TRAINING HOSPITALS NOW HAVE A TOTAL NUMBER OF 658 INTERN OPENINGS, ANOTHER 127 HOSPITALS ARE FULLY ACCREDITED, BUT DO NOT ENGAGE IN TEACHING PROGRAMS. THE PROFESSION WILL BE ABLE TO MATCH ITS INTERNS WITH ITS HOSPITALS THIS YEAR. BUT WHAT ABOUT NEXT YEAR, OR FIVE YEARS FROM NOW? WITH THE EXPANSION OF EXISTING COLLEGES AND THE DEVELOPMENT OF NEW OSTEOPATHIC COLLEGES, MORE THAN 1,000 NEW D.O.'S WILL BE GRADUATING EACH YEAR.

TO PROVIDE THE ROTATING INTERNSHIPS REQUIRED TO DEVELOP WELL-QUALIFIED GENERAL PRACTITIONERS, AOA TRAINING HOSPITALS MUST EXPAND AND ASSUME A GREATER SHARE OF THE TEACHING LOAD. MANY ACCREDITED OSTEOPATHIC HOSPITALS ALSO WILL HAVE TO EXPAND AND REPLACE SUB-STANDARD BEDS AND OUTMODED FACILITIES TO MEET THE RIGID REQUIREMENTS DEMANDED BY THE AOA FOR POSTDOCTORAL TRAINING AND ACCREDITATION REQUIREMENTS.

UNLESS OSTEOPATHIC HOSPITALS ARE CONSIDERED SEPARATELY UNDER EXISTING CERTIFICATE OF NEED LAWS, THE OSTEOPATHIC PROFESSION WILL NOT MEET ITS TRAINING RESPONSIBILITIES TO THESE NEW D.O.'S. AS THE ACCREDITING AGENCY FOR OSTEOPATHIC EDUCATION THE AOA CANNOT COMPROMISE ITS TRAINING STANDARDS.

THE TRAINING ASPECTS OF CERTIFICATE OF NEED LEGISLATION HAVE BEEN IGNORED BECAUSE THEY DO NOT AFFECT THE ALLOPATHIC PROFESSION. FOR THE YEAR 1972-73 THE AMERICAN MEDICAL ASSOCIATION REPORTED 2,487 UNFILLED RESIDENCY AND 6,537 UNFILLED INTERNSHIP POSITIONS. BUT CERTIFICATE OF NEED LAWS DO THREATEN THE OSTEOPATHIC PROFESSION'S ABILITY TO PROVIDE THE FAMILY PRACTITIONERS SO BADLY NEEDED AND SOUGHT AFTER BY THE PUBLIC. PATIENTS SEEKING OSTEOPATHIC HEALTH CARE SHOULD NOT BE DEPRIVED OF IT SIMPLY BECAUSE THERE ARE TOO MANY EMPTY ALLOPATHIC HOSPITAL BEDS IN A GIVEN COMMUNITY.

ARE OSTEOPATHIC PHYSICIANS ELIGIBLE TO TAKE THIER INTERN TRA[illegible]G IN ALLOPATHIC HOSPITALS UNDER THE AEGIS OF THE AMERICAN MEDICAL ASSOCIATION? THE ANSWER TO THIS IS NO. BEGINNING JULY 1, 1975 THE AMA WILL ELIMINATE ALL INTERN PROGRAMS WHEN IT IMPLEMENTS A NEW PROGRAM WHEREBY THE FIRST YEAR OF TRAINING WILL BE GEARED TO A SPECIFIC SPECIALTY OR GROUP OF SPECIALTIES. THESE TRAINING PROGRAMS ONLY PERPETUATE SPECIALIZATION AND WOULD NOT BE APPROVED FOR OSTEOPATHIC GRADUATES.

HEALTH PLANNERS WHO SUGGEST THAT D.O.'S PUT THEIR PATIENTS IN AN EMPTY BED IN AN ALLOPATHIC HOSPITAL RATHER THAN REQUEST ADDITIONAL BEDS IN THEIR OVERCROWDED INSTITUTIONS ARE OVER SIMPLIFYING A COMPLEX PROBLEM. THE PHYSICIAN'S FIRST RESPONSIBILITY IS TO HIS PATIENT. A PHYSICIAN IS MORE EFFECTIVE IN A FAMILIAR SETTING WORKING WITH STAFF AND FELLOW PHYSICIANS OF LONG ASSOCIATION, THAN HE IS IN A STRANGE AND OFTEN UNFRIENDLY ENVIRONMENT AND DEVOID OF ANY CONCEPT OF THE OSTEOPATHIC APPROACH TO HEALTH CARE.

FINALLY, THERE IS THE DISTINCTIVENESS OF OSTEOPATHIC PHYSICIANS AND THE ADDED DIMENSION OF CARE THEY ARE ABLE TO PROVIDE THEIR PATIENTS, WHETHER THE SETTING IS IN THE OFFICE, THE PATIENT'S HOME OR THE HOSPITAL.

AN OSTEOPATHIC HOSPITAL'S DISTINCTIVENESS SHOULD NOT BE EVALUATED BY THE NUMBER OF MANIPULATIVE TREATMENTS ADMINISTERED TO PATIENTS, BUT BY THE APPLICATION OF THE BASIC TENETS OF THE OSTEOPATHIC PHILOSOPHY IN THE PATIENTS HISTORY, PHYSICIAL EXAMINATION, PROGRESS NOTES, AND OVERALL CARE.

THE AOA STRONGLY BELIEVES THAT OSTEOPATHIC FACILITIES SHOULD BE JUDGED SEPARATELY UNDER CERTIFICATE OF NEED LAWS FOR THE FOLLOWING REASONS:

1. NEEDLESS EXPANSION OF HOSPITALS IS NOT IN THE PUBLIC INTEREST.
2. ALL HOSPITALS, ALLOPATHIC OR OSTEOPATHIC, SHOULD BE ALLOWED TO EXPAND THEIR FACILITIES ON THE BASIS OF DEMONSTRATED NEED.

3. OSTEOPATHIC FACILITIES SHOULD BE CONSIDERED SEPARATELY UNDER CERTIFICATE OF NEED LAWS BECAUSE OF THE GREATER NUMBER OF ALLOPATHIC BEDS IN ANY GIVEN AREA AT ANY GIVEN TIME.

4. THAT SEGMENT OF THE PUBLIC THAT SEEKS OUT OSTEOPATHIC HEALTH CARE SHOULD NOT BE SUBJECTED TO OVERCROWDED CONDITIONS SIMPLY BECAUSE THERE ARE BEDS AVAILABLE IN ALLOPATHIC HOSPITALS. THE PATIENT'S FREE CHOICE OF PHYSICIAN ALSO MEANS FREE CHOICE OF HOSPITAL.

5. THE OSTEOPATHIC PROFESSION IS A SEPARATE SCHOOL OF MEDICINE WITH A DIFFERENT PHILOSOPHY OF HEALTH CARE, DIFFERENT TRAINING REQUIREMENTS, DIFFERENT ACCREDITING PROCEDURES AND A DIFFERENT AND UNIQUE EMPHASIS ON TREATING DISEASE.

michigan association of
OSTEOPATHIC PHYSICIANS AND SURGEONS, INC.
33100 FREEDOM ROAD FARMINGTON, MICHIGAN

Sec. 5a. In evaluating an application for a certificate of need, the commission shall take into account the following factors and criteria:

(k) The needs of the patients of both osteopathic and allopathic physicians for independent hospital facilities shall be considered and only those beds shall be authorized where there is a demonstrated need to provide such beds to protect the freedom of patient choice.

The above language was adopted by the Michigan Association of Osteopathic Physicians and Surgeons as an amendment to Michigan's Certificate of Need law.

AOHA newsletter

Cert of Need - Pg 3

August 1, 1975
Volume VI, Number 23

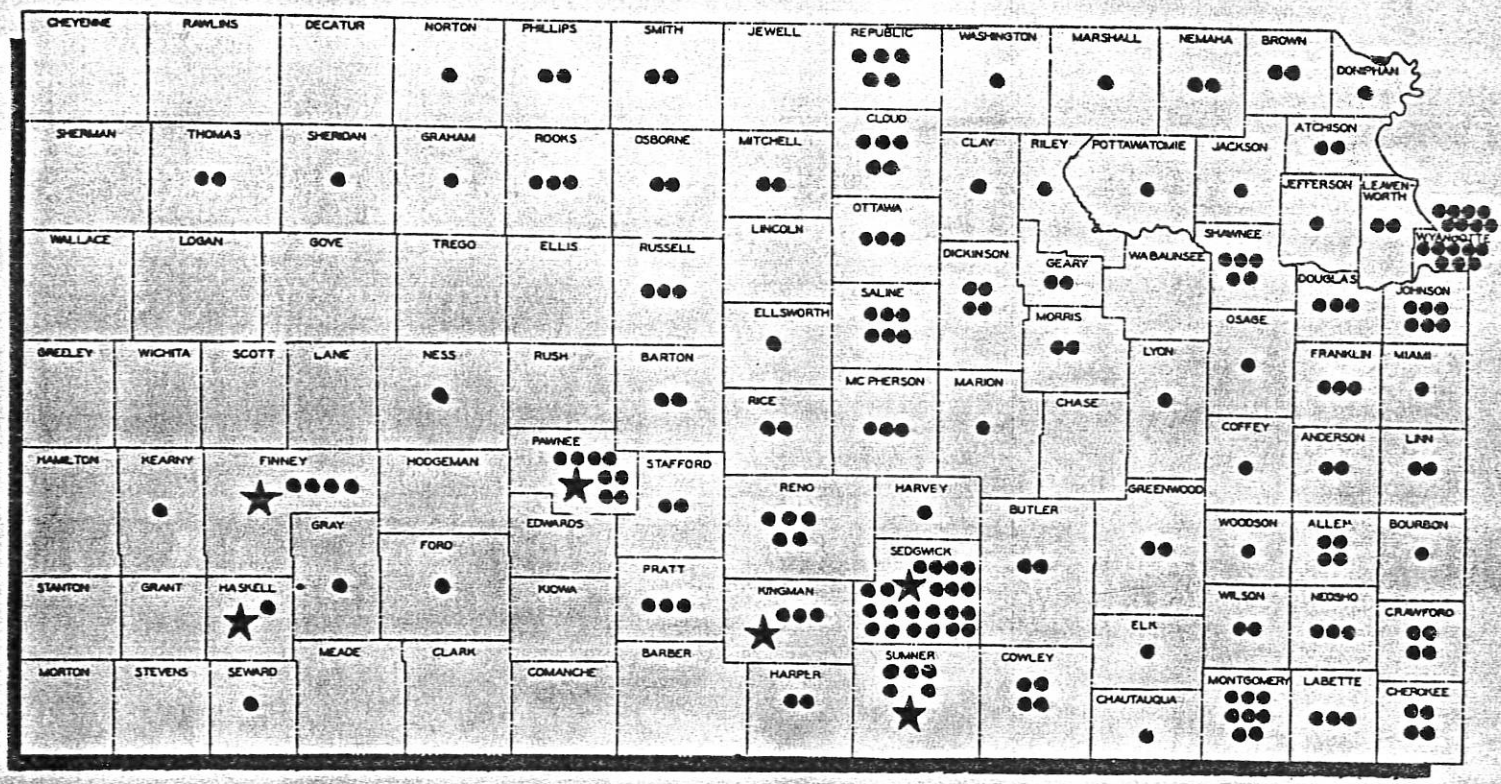
OKLAHOMA C-O-N LAW CONSIDERS OSTEOPATHIC HOSPITALS

Oklahoma has become the 28th state to enact certificate-of-need legislation and the third state, joining Rhode Island and Florida, to provide separate consideration for osteopathic hospitals. In the section which deals with procedures for handling C-O-N applications, the new Oklahoma law specifies that all investigations by the state must consider "the availability of both allopathic and osteopathic facilities and services to protect the freedom of patient choice in the locality."

Such language is vital to perpetuating the uniqueness of the osteopathic profession, and the management of osteopathic hospitals should opt for inclusion of similar phraseology in the development of certificate-of-need legislation in their states.

Osteopathic Training is IN ADDITION to Regular Medical Training

Six colleges in the United States train Doctors of Osteopathy. Educational standards in these schools include (1) [redacted] 4 years pre-professional training in an accredited College or University (2) 4 to 4½ year—or more than 5,000 instruction hours—in the college of osteopathy and (3) one year minimum internship The Osteopathic School of Medicine is a COMPLETE AND ADVANCED School of Medical Practice. It embraces the care and treatment of *all* human ailments and diseases, *including* surgery and the use of drugs.



211 D. O.'s, 6 Privately Maintained Hospitals Give Medical Care to 10% of State's Population

LEGEND
★ Privately maintained hospitals
● Osteopaths

Altho some D.O.'s act primarily as specialists in their field, the vast majority of the profession serve as general practitioners . . . putting their education to its widest possible use in the care of patients. Physicians and Surgeons, D.O. are taught to prescribe drugs, to give anesthetics, administer narcotics, provide complete obstetrical care, treat contagious diseases, and all afflictions by all scientific means including surgery.

Hospitals are maintained in Wellington, Wichita, Kingman, Larned, Garden City and Sublette. All these are built, maintained and operated at high standards without tax money or aid of an organized charity.

THE KANSAS MEDICAL SOCIETY
1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

JERRY SLAUGHTER, EXECUTIVE DIRECTOR
GARY CARUTHERS, EXECUTIVE ASSISTANT
OLIVER E. EBEL, DIRECTOR EMERITUS

November 12, 1975

The Honorable Richard Walker, Chairman
Special Committee on Health and Human Resources
State Capitol Building
Topeka, Kansas 66612

Dear Representative Walker:

The Kansas Medical Society appreciates the opportunity to review and comment on your committee's draft proposals Nos. 22 and 23 regarding the implementation of Public Law 93-641 in Kansas. Time limitations did not allow us to examine the proposals in great depth, thus we will restrict our comments to one area of major concern to the physicians of Kansas.

First, we would like to emphasize that it does not seem necessary that the legislature act to significantly change the certificate of need law during the 1976 session. Rather, we would urge the legislature to use this next year to examine the findings and research of other states and to confer with the various professional and governmental groups that have an active interest in the implementation of this law, so that a well thought out and comprehensive certificate of need law can be enacted in 1977. The enactment of an amendatory certificate of need measure prior to the promulgation of federal regulations would be premature, and we cannot believe there is an immediate need for pursuing such a course.

Concerning your tentative proposals on certificate of need and facilities construction, we would like to identify at this time one of our concerns. We feel it was the intent of Congress(whose definitions you

have adopted) to exempt physicians and their offices in the definition of "health facility" and "medical facility". Although it appears that physicians' offices are exempted in your proposals, we would suggest that for clarification of intent, Section 1(b) of the certificate of need proposal, and Section 1(c) of the facilities construction proposal be amended by adding the following language:

> Certificate of Need. Section 1(b)
> Provided, that the term "health facility" as used in this act shall not apply to individual physicians and their offices.
>
> Facilities Construction. Section 1(c)
> Provided, that the term "medical facility" as used in this act shall not apply to individual physicians and their offices.

Again, we should emphasize that time constraints did not allow us to examine the proposals in great detail. Nevertheless, we appreciate the opportunity to review these advance copies. Additionally, we hope you will permit us to comment further on the proposed measures once our legal counsel has had an opportunity to examine them in depth.

Cordially yours,

Jerry Slaughter
Executive Director

Attachment 3

Statement of the Kansas Hospital Association
Regarding Proposal No. 23 Related to Certificate of Need Legislation

Contained within Public Law 93-641 is the mandate that each state have a certificate of need program which is consistent with federal guidelines. It is clear that the present Kansas Certificate of Need law would not meet certain provisions of the federal guidelines which are yet to be forthcoming. We are told that federal guidelines for Certificate of Need may not be issued until some time in the first quarter of 1976.

It is also clear that there is no mandate for new Certificate of Need legislation for Kansas to be passed during 1976. This is consistent with the wording of the law itself and discussions we have had with federal officials. There are no sanctions, monetary or otherwise, for states which do not enact legislation in the next two years. It would appear, therefore, that since considerable activity is being carried out in many other states with respect to establishing Certificate of Need programs, Kansas could take a more deliberate course of action and develop a comprehensive certificate of need bill during 1976 that would utilize the work and research of many other states. If this were to be done, a number of minor modifications would need to be made to the present Certificate of Need law in order to be consistent with some of the already legislated concepts within P.L. 93-641. One of these would be the transfer of Certificate of Need authority from local areawide health planning councils to the State Agency. Another would be to change the appeals panel to another type of appeals mechanism similar perhaps to that which appears in Proposal No. 23. We can think of no good arguments to support the passage of a bill which does not take maximum advantage of the experience of other states who are involved in studying the issues surrounding Certificate of Need, and certainly before the federal guidelines have been issued.

Following are comments directed specifically at the draft now in the hands of the Committee. There is a very important concept which is notably absent from this document, which we feel is absolutely essential to the effective functioning of a Certificate of Need program. It is, however, possible that this concept can be included in the rules and regulations of the Department of Health and Environment rather than being incorporated into the law. This is the concept which was proposed by the Department of Health and Environment to the Coordinating Council for Health Planning, which they called a "Preapplication Challenge to the State Plan." The Department's concept was that Certificate of Need applications will be reviewed almost entirely according to the relationship the need for a project bears to the State Plan which is in existence. This is a logical approach, except that the state of the art of planning is not precise enough to include everything which may occur with respect to medical technology for a year in advance. For example, it is quite possible for services or equipment to be developed during the course of the year which was not conceived of at the time the State Plan was developed. There needs to be, therefore, some method of challenging or altering the State Plan prior to going to the expense of preparing a Certificate of Need application. The Department of Health and Environment and KHA are in complete agreement upon this point.

In section 5, relating to Capital Expenditures, the "threshold" amount is defined as that which exceeds the lesser of 5% or $150,000. We would submit to the Committee that the 5% figure is obsolete in light of the inflation in the economy in the six years since this concept has been developed. The Kansas Hospital Association recommends that another concept be considered which is more realistic and equitable than the 5% threshold. Our recommendation would be to establish, for

example, a $100,000 threshold for hospitals under 100 beds and a $150,000 threshold for hospitals over 100 beds. We feel that such a concept would insure that major capital expenditures would be fairly scrutinized through the Certificate of Need process. With respect to the "possible elements for Committee consideration" in defining capital expenditures in section 5, KHA would like to propose a concept advanced by the American Hospital Association in its model Certificate of Need legislation. That concept is that the Certificate of Need program apply only to clinically-related or patient care-related areas. Any addition, deletion, or modernization or conversion of clinically-related services such as nursing units, diagnostic facilities, etc. would be included in the Certificate of Need law. Nonclinically-related, nonpatient care areas such as dietary, laundry or maintenance functions would be exempt from the Certificate of Need law. The rationale for this would be that the Health Systems Agency and State Agency have within their scope of review all services operated by a hospital concerned with the care of patients. It would be left to the hospital's discretion as to the support services needed to carry out those services. The Kansas Hospital Association recommends consideration to this concept to the Committee.

Section 6 (b) speaks about a required application fee. The Kansas Hospital Association respectfully submits that this type of regulation is a public function, the performance of which will act for the public good. We feel, therefore, that the public at large, rather than hospital patients, should help subsidize the health planning system. It should be remembered that the majority of dollars needed to run the health planning system, as called for in P.L. 93-641, are federal dollars. Performance of State Agency functions under 93-641 should not result in a major increase over the Department's present expense budget.

Section 6 (c) contains information which shall be included in the application. We submit that this entire list is unnecessary in that a successful applicant will need to show relationship of the proposed project to the needs outlined in the State Health Plan. Legislation could mandate that a Certificate of Need applicant must show that a proposed project would fulfill a need as expressed in the State Health Plan. The specific items to be included in such a review should, we feel, be left to Department of Health and Environment regulations.

In section 22 (p), we would suggest that the Health Systems Agency be given the authority to extend a Certificate of Need, if the applicant can document that an extension of a Certificate of Need is consistent with the needs as outlined in the State Health Plan.

Section 11 would appear to say that an aggrieved hospital, for example, would not be a party to an appeal proceedings. We recommend that it would be improper to exclude the concept that an aggrieved party has the right to initiate and be a party to appeal proceedings.

The Kansas Hospital Association appreciates the opportunity to comment upon the draft of Proposal No. 23. Because of the restricted time schedule within which the Committee must operate, it is not possible for the Kansas Hospital Association to react to some of the legal ramifications of this draft. Following review by our appropriate committees and our legal counsel, we would request the opportunity to make a further statement to the Committee.

Nelson A. Tilden
Vice President, Planning & Hospital Services
Kansas Hospital Association

November 6, 1975

Attachment 4

DRAFT

Kansas Department of Health and Environment

Comments on Three Draft Bills Relating to

(a) Health Planning and Development,

(b) Medical Facilities Survey and Construction,

and (c) Certificate of Need Program

November 11, 1975

Health Planning and Development

Section 4

Subject: Functions of the State Agency

Comment: Paragraphs (a) through (g) of this section have omitted the requirement of Public Law 93-641 Section 1522 (b)(7)(A) and (B) which is to

> "provide for the coordination (in accordance with regulations of the Secretary) with the cooperative system provided for under section 306(e) of the activities of the State Agency for the collection, retrieval, analysis, reporting, and publication of statistical and other information related to health and health care, and (B) require providers of health care doing business in the State to make statistical and other reports of such information to the State Agency;".

We feel it is essential that the state agency be responsible for the development of a statewide health data system that is responsive to the needs of health provider groups, educational institutions, and health planners. A statewide data system should result in the collection of only those data deemed relevant and necessary for effective health planning in Kansas.

The Department of Health and Environment has begun the development of a health data system in the Bureau of

Registration and Health Statistics. The Bureau is presently responsible for collection and reporting of Vital Statistics and has begun the development of a cooperative health manpower data system. The Department has the willingness and the technical capacity to expand its currently operating health data system.

Recommendation: We recommend that Section 4 include an additional paragraph incorporating the concepts of Public Law 93-641 Section 1522 (b)(7)(A) and (B) as stated above.

Section 5 (a)

Subject: Composition of the SHCC

Comment: This section of the law deals with the size and composition of the SHCC. It does not, however, include sufficient detail to provide clear-cut direction for development of the SHCC in Kansas. We would recommend the Kansas law include the detail that is provided in Public Law 93-641 regarding this particular issue (Section 1524 (b)). In addition, we would recommend that the Kansas law establish the size of the SHCC as 28. Our interpretation of the above cited section of the federal law indicates that 17 is the minimum number a SHCC may have in Kansas and still be in compliance, however, this does not give the Governor any flexibility to appoint persons he believes should be included. Twenty-eight would be reasonable,

adequate flexibility and yet avoid the creation of a body too large to be functional.

Recommendation: We recommend that Section 5 (a) be modified to include the specific language that appears in Public Law 93-641 and further that the size of the Kansas SHCC be established as 28 members.

Section 5 (b)

Subject: Nomination by HSAs to SHCC

Comment: This section of the proposed Kansas law reflects language from Public Law 93-641 which is vague and requires additional clarification. If the preceeding recommendation is accepted (a minimum of four members of the SHCC representing each HSA), then this provision would require only five names to be submitted to the Governor for appointment to four positions. This would be unduly restrictive and logistically not essential.

Recommendation: We recommend that the Kansas law be modified requiring the HSAs to nominate a minimum of three persons for each position allocated to the HSA on the SHCC.

Section 9 (e)

Subject: Coordination of Planning and Review Activities by the SHCC

Comment: This section is consistent with Public Law 93-641 in authorizing the SHCC to recommend a uniform format and methodology for preparation of health systems plans for incorporating into the state health plan. Public Law 93-641 fails to designate a final authority for resolution of disagreement between HSAs and/or the state agency regarding plan formats, however, it does require that the SHCC have final authority for modification, as appropriate, of health systems plans and the state health plan. With this final approval and disapproval authority, it would seem appropriate to empower the SHCC to resolve any disagreements on format prior to the preparation of plans rather than after the fact.

Recommendation: We recommend that this section be modified authorizing the state agency to recommend planning formats and methodologies to the SHCC and indicating that the SHCC will be the final authority in approving or disapproving planning formats adopted by the state agency and health systems agencies.

Medical Facilities Survey and Construction

Section 11

Subject: HSA Approval and Disapproval of Title XVI Funds

Comment: The draft Kansas bill is vague on the role of the health systems agencies in the review and approval or disapproval of applications for grants, loans and loan guarantees for facilities development as provided under Title XVI of Public Law 93-641. Public Law 93-641 requires that each application be reviewed by the state agency and the appropriate health systems agency in accordance with provisions in Section 1513 (e) and Section 1604 (c) and (f).

Recommendation: We recommend that the Kansas draft be modified to incorporate the intent of Public Law 93-641 providing the authority of health systems agencies to approve and disapprove facilities development grants, loans and loan guarantees.

Section 14

Subject: Transmittal of Federal Funds

Comment: The intent of Title XVI in Public Law 93-641 is to assure no projects receive federal funding through the state that have not first been deemed needed by the state agency. This can be achieved by indicating in this Act that no funds under Title XVI

of PL 93-641 may be allocated until the applicant has been awarded a certificate of need, provided such a certificate is required under certificate of need legislation.

Recommendation: We recommend that Section 14 be amended to include the following sentence "The Secretary may not transmit any funds related to projects requiring a certificate of need until and unless a certificate of need is granted by the state agency".

General Comment

It would appear that the effort to amend existing Kansas legislation regarding medical facilities survey and construction requires a great deal of change to achieve conformance with Public Law 93-641. Even with those extensive amendments indicated in the draft available, a great deal of the detailed procedural aspects of the federal law is not addressed in the draft Kansas legislation. It would appear that preparation of a new draft would be more efficient than such extensive modifications to existing legislation. The draft bills on certificate of need and health planning under review indicate the validity of this observation.

Certificate of Need Program

Section 1 (a)

Subject: Definition of Licensing Agency

Comment: This section attempts to establish the definition of "licensing agency" and appears to succeed in establishing that two separate state agencies (Health and Environment, and Social and Rehabilitation Services) are collectively the "licensing agency". This seems to be unnecessarily complicated and a more precise definition should be developed.

Recommendation: This section of the law should be modified to identify and define those licensing agencies responsible for institutions and programs affected by certificate of need law.

Section 1 (b)

Subject: Definition of Health Facilities

Comment: This section of the law defines in very broad terms health facilities and services which would apparently be affected by the certificate of need program. We do not feel the state agency has or will be able to determine with reasonable accuracy the need for a wide range of services that must be developed in accordance with unique requirements in the many communities

of this state. It is necessary to confine the regulation of facilities development to very specific areas in which experience in present methodology makes certificate of need programs possible. In Kansas we think the certificate of need program should be begun by concentrating on three specific type institutions: (a) licensed hospitals (medical and mental), (b) licensed skilled nursing facilities, and (c) licensed intermediate care nursing facilities. Expansion of the certificate of need program beyond this set of institutions should be attempted only when adequate methods for projection of needs are available.

Recommendation: We recommend that Kansas' certificate of need law specify precisely what institutions are affected and, that in the immediate future, only licensed hospitals, skilled nursing facilities and intermediate care facilities be so affected.

Section 1 (f)

Subject: Review Agency

Comment: Kansas will be expending a great deal of resources supporting the development of the state health coordinating council. This council in turn will have under the facilities survey and construction act responsibility for approving the medical facilities plan. It would seem appropriate that the state health

coordinating council be designated as the official review agency for matters pertaining to the certificate of need program. This would provide for participation of reasonably well informed reviewers with adequate staff support and would help avoid the necessity of yet another state supported effort to provide for such review.

Recommendation: We recommend that this section be modified to designate the SHCC as the "review agency".

Section 3

Subject: Certificate of Need Issuing Agency

Comment: This section implies that either the state agency or the review agency may award a certificate of need.

Recommendation: We recommend this section be modified to indicate that the state agency shall award a certificate of need if approved by the appeal agency.

Section 3

Subject: Application Requirements for Licensure

Comment: This section also indicates that an applicant for licensure must include a certificate of need along with the application but does not specifically say that a certificate of need is required prior to granting of a license.

Recommendation: We recommend this section be modified to state specifically that a certificate of need is required to be eligible for licensure of a new or expanded facility.

Sections 5 (a) (1) and (2)

Subject: Projects Requiring Certificate of Need

Comment: This section establishes two classes of projects requiring certificate of need, the first being facilities and the second being services. Consistent with our previous recommendation regarding a specific definition of projects affected by certificate of need, we would recommend the deletion of references to health services.

Recommendation: We recommend that Section 5 (a)(1) be amended by adding the following to the end of the subsection "the construction or acquisition of equipment equal to or greater than the thresholds established below". We further recommend the deletion of Subsection 5 (a)(2).

Section 6 (b)

Subject: Application Fee

Comment: This section refers to an application fee. We question the necessity of an application fee and consider it a potential obstacle for certain type projects. It would appear that the large hospitals in the state presently pay no license fees and

it would be an inequity to require newly formed institutions attempting to develop needed health services to pay a fee related to a program which doesn't even exist.

Recommendation: We recommend the deletion of any reference to an application fee.

Section 6 (b)

Subject: Completed Application

Comment: Reference is made in this section to the requirement for a completed application. In many instances applications may be filed which are not consistent with the state medical facilities plan. As a consequence, the applicant would be going to considerable expense in applying against a major published criteria for review of his project. We feel it would be appropriate to allow applicants to challenge the state plan in advance of going to the expense of preparing a final application.

Recommendation: We recommend this section of the law be modified to provide the applicant with the option of filing a challenge to the state plan prior to submission of a formal application. This option should contain the provision for assignment of priority to the applicant's subsequent application, provided the state plan challenge is successful. We further recommend authorizing the state agency to develop appropriate rules and

regulations to make the concept operative.

Section 6 (d)

Subject: Fees

Comment: This section also refers to an application fee which we do not feel is appropriate.

Recommendation: We recommend deletion of any reference to any application fees.

Section 8 (a)

Subject: State Review Procedures

Comment: The draft requires final action by the state agency 60 days within submission of an application. We feel this places an extraordinary time constraint on the state agency in consideration of the complexity and unusual nature of many potential applications.

Recommend: We recommend the time frame for final action by the state agency be established at 90 days.

Section 9

Subject: Appeal Procedures

Comment: Section 9 restricts the opportunity to appeal to the applicant. We would recommend that the appeal procedure be open to other aggrieved parties.

Recommendation: We recommend this section of the law be modified to allow other parties than the applicant to appeal subject to rules established by the state agency.

Section 12

Subject: Review Agency

Comment: Consistent with our previous recommendation, we feel that the state health coordinating council should be established as the review agency.

Recommendation: We recommend that Section 12 be amended to reflect the role of the SHCC as the review agency.

Section 26

Subject: Exemption for State Agencies

Comment: Is it appropriate for the state to operate a program of facility regulation for all health facilities except its own. Should there be one standard of review and should the state establish conformity of its programs with those in the balance of the health delivery system.

Recommendation: Should the exemption for the state agencies be deleted.

Section 27

Subject: Civil Actions

Comment: The penalty related to failure to conform to the certificate of need program is tied to the licensure process. We see no need for provision of civil action related to the certificate of need program.

Recommendation: We recommend deletion of Section 27.

Section 28

Subject: Misdemeanor

Comment: Same as above for civil actions

Recommendation: We recommend deletion of Section 28.

HOUSE BILL NO._____

By Special Committee on Health and Human Resources

Re Proposal No. 23

AN ACT establishing a certificate of need program; requiring a certificate of need before certain projects may be undertaken; repealing K. S. A. 65-2a02 to 65-2a06, inclusive, 65-2a08 to 65-2a14, inclusive, and K. S. A. 1975 Supp. 65-2a01 and 65-2a07.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act: (a) "Licensing agency" means the department of health and environment with reference to facilities licensed pursuant to K. S. A. 39-927 and 65-428, the department of social and rehabilitation services with reference to facilities licensed pursuant to K. S. A. 75-3307b, exclusive of facilities for the mentally retarded and pursuant to K. S. A. 1975 Supp. 65-4012 and K. S. A. 1975 Supp. 75-5375 and the commissioner of insurance with reference to organizations granted certificates of authority pursuant to K. S. A. 1975 Supp. 40-3204.

(b) "Health facility" means medical care facility, psychiatric hospital, health maintenance organization, skilled nursing home, intermediate nursing care home, intermediate personal care home, home health agency, provider of outpatient physical therapy services including speech pathology services, except that such term shall not apply with respect to outpatient physical therapy services performed by a physical therapist in his or her office or in a patient's home, kidney disease treatment center, including centers not located in a medical care facility, health center and family planning clinic.

(c) "State agency" means the secretary of health and environment.

(d) "Health systems agency" means an agency designated under section 1515 of public law 93-641 (42 U.S.C. 3001-4) [shall include health systems agencies conditionally designated under such section].

(e) "Health service area" means the area for which a health systems agency is responsible.

(f) "Review agency" means the agency of the state designated by the governor to review appeals from decisions of the state agency relating to the granting or refusing to grant certificates of need.

(g) "Application" means an application for a certificate of need made to the state agency and shall be in such form and shall contain such information as the state agency may prescribe.

(h) "Health facility services" means the health services provided through health facilities and includes the entities through which such services are provided.

(i) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof.

Sec. 2. Upon the effective date of this act, no person shall undertake a project described in section 5 unless a certificate of need has been obtained under the provisions of this act.

Sec. 3. An application to the licensing agency for a new license and not the renewal of a valid license, or an application to the licensing agency from an existing health facility for licensure of facilities or services of a project requiring a certificate of need as set forth in section 5 shall include a certificate of need from the state agency or review agency, if appealed. The certificate of need forms shall be developed by the state agency.

Sec. 4. A certificate of need may be granted only after an opportunity has been given to the appropriate health systems agency to review the project proposal, in accordance with procedures established in section 7, and the state agency has

determined that, on the basis of evidence presented at the hearing with respect to community need as reflected in the state health plan, there is a sufficient need for the proposed project.

Sec. 5. (a) Projects requiring a certificate of need before they are undertaken include, and shall be limited to, the following:

(1) The construction of a new health facility.

(2) The construction of additional bed capacity in a health facility[, the conversion of an existing bed category to a different bed category, an increase in a bed category].

(3) Modernization of an existing health facility requiring a capital expenditure.

(4) The creation, expansion, addition or deletion of health facility services.

(b) As used in this section, "capital expenditures" means:

(1) An expenditure, including an expenditure for a construction project undertaken by the facility as its own contractor, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which exceeds the lesser of five percent (5%) of the health facility's operating expense in the most recent fiscal year or one hundred fifty thousand dollars ($150,000). [The total individual project cost shall be limited to all depreciable assets to be owned or used by the health facility as a result of the project and which would normally be capitalized under generally accepted accounting procedures.]

<u>Possible Elements for Committee Consideration in Defining Capital Expenditure</u>.

[(2) The cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is to be made shall be included in determining whether such cost exceeds the lesser of five percent (5%) of the health facility's operating expense in the most recent fiscal year or one hundred

fifty thousand dollars ($150,000).

(3) Where the estimated cost of a proposed project, including cost escalation factors appropriate to the area in which the project is located is certified, within sixty (60) days of the date on which the obligation for such expenditure is incurred, by a registered architect or licensed engineer to be one hundred fifty thousand dollars ($150,000) or less, or less than five percent (5%) of the health facility's operating expense in the most recent fiscal year, such expenditure shall be deemed not to exceed one hundred fifty thousand dollars ($150,000) or five percent (5%) or more of the health facility's operating expense in the most recent fiscal year, regardless of the actual cost of such project. Where the actual cost of the project exceeds one hundred fifty thousand dollars ($150,000), the health facility on whose behalf such expenditure is made shall provide written notification of such cost to the state agency not more than thirty (30) days after the date on which such expenditure is incurred. Such notification shall include a copy of the certified estimate.

(4) A capital expenditure includes expenditures associated with substantial changes in the services of a health facility which results in the addition of a clinically related diagnostic, curative or rehabilitative service not previously provided in the facility or the termination of such a service which had previously been provided in the facility.

(5) Where a person obtains under lease or comparable arrangement or through donation any health facility or part thereof or equipment for a health facility, the expenditure for which would have been considered a capital expenditure if the person had acquired the facility by purchase, such acquisition shall be deemed a capital expenditure.

(6) Any change in a proposed capital expenditure which itself meets the criteria set forth in subsection (b) shall be deemed a capital expenditure. An increase or decrease in the cost of a proposed capital expenditure, which increase or decrease is

not related to proposed projects described in subsection (a) may be exempt, at the option of the state agency, from review under this act.

(7) A capital expenditure includes the total cost of the proposed project as certified by a registered architect or licensed engineer on preliminary plans approved by the state agency or equipment projects including the total costs of proposed equipment.]

Sec. 6. (a) Applicants who are required to apply for a certificate of need under section 5 shall submit such application to the state agency in accordance with procedures established in rules and regulations duly adopted by the state agency.

(b) Except as specifically exempted by law or regulation, every person desiring a certificate of need under this act shall file a completed application and the required application fee with the state agency. Such application and any modifications shall be on forms prescribed and furnished by the state agency.

(c) Each application shall include at least the following information:

(1) The geographical area and the population to be served by the project, as well as projections of population growth.

(2) The anticipated demand for the health care service or services to be provided.

(3) A description of the service or services to be provided.

(4) The use, adequacy and availability of existing facilities and services within the area to be served offering the same or similar health care services.

(5) The anticipated demand for the health service or services to be provided.

(6) Projected cost estimates of capital expenditures and operating expenses.

(7) Projected staffing of the service.

(8) Schematic plan if construction is included in the application.

(9) The benefit to the community which would result from the development of the project, as well as the anticipated impact on other health providers offering the same or similar health care services in the geographical area to be served by the applicant.

(10) Other information which may be required by the state agency.

(d) An application shall be deemed filed when it contains all required information and when the filing fee, in an amount established by the state agency by duly adopted rules and regulations of not more than _____ dollars ($), is received by the state agency. A filed application shall be a public document and shall be available for inspection at the offices of the health systems agency and the state agency. A copy thereof shall be furnished to any person upon request and payment of a reasonable fee established by the state agency or the health systems agency in an amount sufficient to defray the costs thereof. A completed application may be amended or withdrawn by the applicant at any time without prejudice, but any amendment to an application, except as the state agency and the applicant may otherwise agree, shall cause the amended application to be treated as a new application for purposes of the time limits of this act.

(e) If the state agency determines that the application is incomplete, it shall notify the applicant and the appropriate health systems agency within fifteen (15) days of the receipt of the application advising the applicant that additional information is required. After such notice the application shall not be deemed filed until a complete application is received by the state agency. If the notice that the application is incomplete is not given within fifteen (15) days, the application shall be deemed complete and the state agency shall thereupon proceed with its review. When the application is filed the state agency shall promptly publish notice of its filing in a newspaper of general circulation in the geographical area to be served by

the project.

Sec. 7. At the same time the application is submitted to the state agency, a copy shall be submitted to the appropriate health systems agency. The health systems agency shall review, in accordance with procedures established pursuant to section 1532 of public law 93-641 (42 U.S.C. 300n-1), and comment upon the application and submit its findings and recommendations to the state agency within forty-five (45) days of the receipt of the completed application.

Sec. 8. (a) The state agency shall review, in accordance with procedures established pursuant to section 1532 of public law 93-641 (42 U.S.C. 300n-1), and either approve, approve subject to modification or deny an application within sixty (60) days of receipt of the completed application.

(b) If the state agency's decision differs from the health systems agency, the state agency shall submit to the appropriate health systems agency a statement of its reasons for making such decision.

[(c) Notice of the substance of the decision shall be published by the state agency in a newspaper of general circulation within the area to be served within ten (10) days following its issuance.]

Sec. 9. Any decision issued pursuant to section 8 shall take effect thirty (30) days following its issuance unless within such time an applicant requests a hearing with the review agency or a written protest is filed by the appropriate health systems agency with the review agency. The applicant's request for a hearing or the filing of a written protest shall operate to suspend and stay the state agency's certificate of need decision pending the hearing and entry of a final decision. If the state agency does not issue its decision within sixty (60) days of the receipt of a completed application, it shall be deemed that the state agency has approved the application for a certificate of need.

Sec. 10. As soon as a request for hearing on a certificate

of need decision is received from the applicant or the appropriate health systems agency, the review agency shall set a hearing date within thirty (30) days of the date the protest or request for hearing was received. The place of hearing shall be within the region and reasonably convenient to the site of the project. The review agency shall cause to be published, at least fifteen (15) days prior to the hearing, a notice summarizing the application and the state agency's recommendation, with such particulars as the review agency may deem necessary, including but not limited to the name and address of the applicant, the type of project, and the date, time and place of the hearing, in a newspaper of general circulation in the geographical area to be served by the project. In addition, the review agency shall send copies of such notice to the applicant, the state agency, the health systems agency, all other health facilities in the geographical area to be served and any persons requesting such notice.

Sec. 11. Parties to the review proceedings shall be the applicant, the state agency, and the health systems agency from the area in which the protest was filed. Any other person shall have the right to appear and be heard at the hearing, but shall not be a party to the proceedings.

Sec. 12. The hearing may be held by the review agency or a hearing officer, as ordered by the review agency. Every hearing shall be held in the geographical area referred to in the application and shall be presided over by a hearing officer assigned by the review agency. The hearing officer shall rule on the admission and exclusion of evidence and the review agency on matters of law. The review agency shall exercise all other powers relating to the conduct of the hearing, but may delegate any or all of such powers to the hearing officer.

Sec. 13. In any hearing conducted pursuant to this act, the hearing officer shall have authority to administer oaths or affirmations.

Sec. 14. (a) Prior to commencement of the hearing, the

assigned hearing officer shall issue subpoenas at the request of any party for attendance of any witness or production of documents at the hearing. After the hearing has commenced, the hearing officer may issue subpoenas at the request of a party.

(b) All witnesses appearing pursuant to subpoena, other than the parties or officers or employees of the state or any political subdivision thereof, shall be entitled to the same witness and mileage fees as are allowed witnesses in proceedings in a district court. Witness and mileage fees shall be paid by the party at whose request the witness is subpoenaed.

(c) Any person summoned to attend as witness at a proceeding pursuant to this act who refuses or neglects, without lawful excuse, to attend pursuant to such summons, and any person who, being present at a proceeding pursuant to this act, willfully refuses to be sworn, to answer any material and proper question or to produce, upon reasonable notice, any material and proper books, papers, or documents in his or her possession or under his or her control [shall be guilty of a misdemeanor and upon conviction shall be fined not more than five hundred dollars ($500)].

(d) On the verified petition of any party, the assigned hearing officer may order that the testimony of any material witness residing within or without the state be taken by deposition in the manner prescribed by law for depositions in civil actions. The petition shall set forth the nature of the pending proceeding, the name and address of the witness whose testimony is desired, a showing of the materiality of his or her testimony, a showing that the witness will be unable or cannot be compelled to attend and shall request an order requiring the witness to appear and testify before an officer named in the petition for that purpose.

Sec. 15. At every hearing conducted pursuant to section 12:

(a) Oral evidence shall be taken only on oath or affirmation.

(b) Each party shall have the right to call and examine

witnesses, to introduce exhibits, to cross-examine opposing witnesses on any matter relevant to the issues, even though that matter was not covered in the direct examination, to impeach any witness regardless of which party first called him or her to testify, and to rebut the evidence against him or her.

(c) The hearing need not be conducted according to technical rules relating to evidence and witnesses. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rules which might make improper the admission of such evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. The rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the proceeding, and irrelevant and unduly repetitious evidence shall be excluded.

(d) In reaching a proposed decision, decision, or decision upon reconsideration, official notice may be taken, either before or after submission of the case for decision, of any generally accepted technical or scientific matter within the review agency's special field, and of any fact which may be judicially noticed by the courts of this state. Parties present at the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein or appended thereto. Any such party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the review agency.

Sec. 10. At every hearing conducted pursuant to section 12:

(a) A transcript of a hearing shall be available to anyone making a request therefor who has deposited with the review agency an amount of money which the review agency has determined

to be necessary to cover the costs of preparation of the transcript.

(b) All parties shall have the right to be represented by counsel.

Sec. 17. Within fifteen (15) days after the close of the hearing, the hearing officer shall prepare and submit to the review agency a proposed decision in such form that it may be adopted by the review agency as its decision on the application. If the hearing is held by the review agency, those members who heard the matter shall advise the hearing officer of their recommendations concerning the proposed decision.

The proposed decision shall be based on the evidence and exhibits admitted at the hearing and on the considerations set forth in sections 4 and 5. The proposed decision shall be in writing and shall contain proposed findings of fact, determination of the issues presented and a recommended action on the application.

The hearing officer shall forward to the review agency the transcript of all testimony and oral argument, all exhibits and any written argument, as soon as it is reasonably practicable.

Sec. 18. Upon receipt, a copy of the proposed decision shall be filed by the review agency as a public record, and within five (5) days thereafter copies shall be served by the review agency on the applicant and the other parties and participants in the hearing, and copies shall be mailed to all other persons so requesting. Accompanying each such copy shall be a notice of the date, time and place of the review agency's meeting to consider the proposed decision, which meeting shall be not less than fifteen (15) days nor more than thirty (30) days following the date of such notice.

Sec. 19. Prior to the meeting of the review agency, the members shall have read the proposed decision, the transcript of the testimony and oral argument, the exhibits and written argument.

At the meeting scheduled by the review agency to consider

the proposed decision, the review agency shall receive oral and written argument from any party. If the proposed decision is not so adopted, the review agency may decide the case upon the entire record, including the transcript, and oral and written argument, with or without taking additional evidence, and modify or reverse the proposed decision if the review agency finds that the proposed decision is not in accordance with the provisions of sections 4 and 5.

Sec. 20. (a) The decision of the review agency shall set forth the findings of fact and a determination of the issue presented. Any decision granting a certificate of need may be subject to lawful conditions prescribed by the state agency which are made applicable by rules and regulations of the state agency to all certificates of need.

(b) The decision of the review agency on the application shall be rendered within ten (10) days after the meeting is held to consider a proposed decision pursuant to section 19. Copies of the decision shall be served on each party and his or her attorney, and shall be mailed to all other persons to whom the proposed decision was mailed pursuant to section 18.

(c) The decision shall be effective thirty (30) days after the date of issuance, unless otherwise provided in the decision or unless stayed by a court on appeal.

Sec. 21. If the review agency does not adopt a decision within sixty (60) days of the close of the hearing provided for by this act, the application shall be deemed approved.

Sec. 22. (a) An approval, approval subject to modification or disapproval of an application shall become final when all rights to appeal have been exhausted. When a decision provided for in this act which approves or approves subject to modification an application has become final, the state agency shall issue a certificate of need to the applicant.

(b) Approval shall terminate twelve (12) months after the date of such approval unless the applicant has commenced construction or conversion to a different license category and is

diligently pursuing the same to completion as determined by the state agency; or unless the approval is extended by the state agency for an additional period of up to twelve (12) months upon the showing of good cause for the extension.

Sec. 23. The applicant may appeal the approval or disapproval of the review agency to the district court of the county in which the aggrieved party is located or is to be located. The district court shall have the jurisdiction to affirm, modify, vacate or reverse the approval or disapproval being appealed. Notice of said appeal shall be filed in the office of the clerk of the district court, and a copy thereof served upon the state agency and review agency within ten (10) days thereafter. The review agency shall, within twenty (20) days after being served, file with the clerk of the district court all records of the health systems agency, state agency and review agency in the case, including the evidence taken at previous proceedings.

Sec. 24. [Depreciable assets that are destroyed or made inoperable by a catastrophe, or a disaster due to an act of nature or forces thereof, may be replaced, repaired or refurbished without obtaining a certificate of need.]

Sec. 25. This act shall not apply to any health facility project proposal granted a certificate of need prior to the effective date of this act, except that the provisions of subsection (b) of section 22 of this act shall apply to any health facility project proposal granted a certificate of need less than twelve (12) months prior to the effective date of this act or having the approval of a certificate of need extended under the provisions of K. S. A. 65-2a08 for a period of time terminating subsequent to the effective date of this act.

Sec. 26. [This act shall not apply to any health facility that is owned or operated by the state of Kansas or United States government.]

[Sec. 27. The state agency may file a civil action to enjoin any person from undertaking a project described in section

5 as requiring a certificate of need unless a certificate of need has been granted under this act.]

[Sec. 28. Any person undertaking a project described in section 5 as requiring a certificate of need without first having obtained the required certificate of need shall be guilty of a class _____ misdemeanor.]

Sec. 29. K. S. A. 65-2a02 to 65-2a06, inclusive, 65-2a08 to 65-2a14, inclusive, and K. S. A. 1975 Supp. 65-2a01 and 65-2a07 are hereby repealed.

Sec. 30. This act shall take effect and be in force from and after its publication in the statute book.

HOUSE BILL NO._____

By Special Committee on Health and Human Resources

Re Proposal No. 22

AN ACT concerning the Kansas medical facilities survey and construction act; amending K. S. A. 65-410, 65-416, 65-419 and K. S. A. 1975 Supp. 65-411, 65-412, 65-413, 65-414, 65-415, 65-417, 65-418, 65-420, 65-421, 65-422 and 65-423 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

Sec. 1. K. S. A. 65-410 is hereby amended to read as follows: 65-410. This act may be cited as the Kansas ~~hospital and~~ medical facilities survey and construction act.

Sec. 2. K. S. A. 1975 Supp. 65-411 is hereby amended to read as follows: 65-411. As used in this act:

(a) "Secretary" means the secretary of health and environment.

~~(b) "Advisory hospital council" means the advisory hospital council created by K. S. A. 65-434 and any amendments thereto.~~

~~(c)~~ (b) "The federal act" means ~~title~~ titles VI and XVI of the United States public health service act (42 U.S.C. 291 et seq.) and any amendments thereto.

~~(d) "The surgeon general" means the surgeon general of the public health service of the United States.~~

~~(e)~~ (c) ~~"Hospital"~~ "Medical facility" includes public health centers and general, special, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, extended care facilities, facilities related to programs for home health services, self-care units, diagnostic or diagnostic and treatment centers, outpatient medical facilities, rehabilitation facilities, facilities for long-term care and central service facilities operated

in connection with hospitals and also includes educational or training facilities for health professional personnel operated as an integral part of a hospital, and other facilities as may be designated by the secretary of health, education and welfare for the provision of health care to ambulatory patients and other medical facilities for which federal aid may be authorized under the federal act, but ~~does~~ shall not include any hospital furnishing primarily domiciliary care. Terms used in this subsection which are defined in the federal act shall have the meaning ascribed to such terms in the federal act.

~~(f)~~ (d) "Public health center" means a publicly owned facility for the provision of public health services, including related facilities such as laboratories, clinics, and administrative offices operated in connection with public health centers.

~~(g)~~ (e) "Nonprofit ~~hospital" and "nonprofit~~ medical facility" means any ~~hospital or~~ medical facility owned and operated by one or more nonprofit corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

~~(h) "Medical facilities" means diagnostic or diagnostic and treatment centers, rehabilitation facilities and nursing homes as those terms are defined in the federal act, and such other medical facilities for which federal aid may be authorized under the federal act.~~

(f) "Medical facility project" means a project for the modernization of a medical facility, the construction of a new outpatient or inpatient medical facility or the conversion of an existing medical facility for the provision of new health services.

Sec. 3. K. S. A. 1975 Supp. 65-412 is hereby amended to read as follows: 65-412. The secretary, ~~through the division of health,~~ shall constitute the sole agency of the state for the purpose of:

~~(1)~~ (a) Making an inventory of existing ~~hospitals and~~ medical facilities, surveying the need for construction of ~~hospitals~~

~~and~~ medical facilities~~,~~ and developing a program of construction as provided in K. S. A. 65-415 to 65-417, inclusive, and any amendments thereto; and

~~(2)~~ (b) developing and administering a state medical facilities plan ~~for the construction of public and other non-profit hospitals and medical facilities~~ as provided in K. S. A. 65-418 to 65-423, inclusive, and any amendments thereto.

Sec. 4. K. S. A. 1975 Supp. 65-413 is hereby amended to read as follows: 65-413. In carrying out the purposes of the act, the secretary is authorized and directed:

(a) To require such reports, make such inspections and investigations and prescribe such regulations as he or she deems necessary;

(b) to provide ~~such~~ methods of administration~~,--appoint--a director--and-other-personnel-of-the-division~~ and take ~~such~~ other action as may be necessary to comply with the requirements of the federal act and ~~the~~ federal regulations ~~thereunder~~ adopted pursuant thereto;

(c) to procure in his or her discretion the temporary or intermittent services of experts or consultants or organizations thereof, by contract, when such services are to be performed on a part-time or fee-for-service basis and do not involve the performance of administrative duties;

(d) ~~to the extent that he considers desirable to effectuate the purposes of this act,~~ to enter into agreements for the utilization of the facilities and services of other departments, agencies, and institutions, public or private, to the extent that the secretary considers desirable to effectuate the purposes of this act;

(e) to accept on behalf of the state and to deposit with the state treasurer any grant, gift or contribution made to assist in meeting the cost of carrying out the purposes of this act~~,~~ and to expend the same for such purpose;

(f) to make an annual report to the governor and to the legislature on activities and expenditures pursuant to this act,

including recommendations for such additional legislation as the secretary considers appropriate to furnish adequate hospital and medical facilities to the people of this state.

Sec. 5. K. S. A. 1975 Supp. 65-414 is hereby amended to read as follows: 65-414. The ~~advisory hospital council~~ statewide health coordinating council shall advise and consult with the secretary with respect to the administration of this act. ~~Members of the advisory hospital council attending meetings of such council, or attending a subcommittee meeting thereof authorized by such council, shall be paid amounts provided in subsection (e) of K. S. A. 1975 Supp. 75-3223. The advisory council shall meet as frequently as the secretary deems necessary but not less than once each year. Upon request by three (3) or more members of the hospital advisory council, the secretary shall call a meeting of the council.~~ The statewide health coordinating council shall consider the state medical facilities plan and determine whether or not such plan is consistent with the state health plan.

Sec. 6. K. S. A. 1975 Supp. 65-415 is hereby amended to read as follows: 65-415. The secretary is authorized and directed to make an inventory of existing ~~hospitals and~~ medical facilities~~, including public, nonprofit and proprietary hospitals and medical facilities,~~ to survey the need for modernization or construction of ~~hospitals and~~ medical facilities~~,~~ or for the conversion of existing medical facilities in order to provide new health services; and, on the basis of such inventory and survey, to develop a program for the construction, modernization or conversion of such ~~public and other nonprofit hospitals and~~ medical facilities as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate ~~hospital and~~ medical facility services to all the people of the state.

Sec. 7. K. S. A. 65-416 is hereby amended to read as follows: 65-416. The ~~construction program~~ state medical facilities plan shall provide, in accordance with ~~regulations prescribed~~

~~under~~ the federal act and federal regulations adopted pursuant thereto, for adequate ~~hospital and~~ medical facilities for the people residing in this state and insofar as possible shall provide for their distribution throughout the state in such manner as to make all types of ~~hospital and~~ medical facility services reasonably accessible to all persons in the state.

Sec. 8. K. S. A. 1975 Supp. 65-417 is hereby amended to read as follows: 65-417. The secretary is authorized to make application to the ~~surgeon general~~ federal secretary of health, education and welfare for federal funds to assist in carrying out the survey and planning activities herein provided. Such funds shall be deposited in the state treasury and shall be available to the secretary for expenditure for carrying out the purposes of K. S. A. 65-415 to 65-417, inclusive, and any amendments thereto. Any such funds received and not expended for such purposes shall be repaid to the treasury of the United States.

Sec. 9. K. S. A. 1975 Supp. 65-418 is hereby amended to read as follows: 65-418. The secretary shall prepare a state medical facilities plan and, upon approval of ~~same~~ the plan by the ~~advisory hospital council~~ statewide health coordinating council, shall submit the plan to the ~~surgeon general a state plan which shall include the hospital and medical facilities construction program developed under K. S. A. 65-415 to 65-417, inclusive, and any amendments thereto, and which shall provide for the establishment, administration, and operation of hospital and medical facilities construction activities in accordance with the requirements of the federal act and regulations thereunder~~ federal secretary of health, education and welfare. The secretary shall, prior to the submission of such plan to the ~~surgeon general~~ federal secretary of health, education and welfare, give adequate publicity to a general description of all the provisions proposed to be included therein, and hold a public hearing at which all persons or organizations with a legitimate interest in such plan may be given an opportunity to express their views.

After approval of the plan by the ~~surgeon general~~ federal

secretary of health, education and welfare, the secretary ~~shall publish a general description of the provisions thereof in at least one newspaper having general circulation in each county in the state, and~~ shall make the plan, or a copy thereof, available upon request to all interested persons or organizations and shall charge a reasonable fee for any copy of such plan distributed to interested persons or organizations. The secretary shall ~~from time to time~~ review periodically the ~~construction program~~ state medical facilities plan and submit to the ~~surgeon general~~ federal secretary of health, education and welfare any modifications ~~thereof~~ of such plan which ~~it~~ the secretary may find necessary and may submit to the ~~surgeon general~~ federal secretary of health, education and welfare such modifications of the state medical facilities plan, not inconsistent with the requirements of the federal act, as ~~he~~ the secretary may deem advisable~~:~~ ~~Provided, That no~~. No ~~such~~ modifications of the state medical facilities plan shall be submitted to the ~~surgeon general~~ federal secretary of health, education and welfare until ~~the same have been~~ approved by the ~~advisory hospital council~~ statewide health coordinating council.

Sec. 10. K. S. A. 65-419 is hereby amended to read as follows: 65-419. The state medical facilities plan shall set forth the relative need for the ~~several~~ medical facility projects included in ~~the construction program~~ such plan determined in accordance with ~~regulations prescribed pursuant to~~ the federal act and federal regulations adopted pursuant thereto, and provide for the ~~construction~~ medical facility projects, insofar as financial resources available therefor and for maintenance and operations make possible, in the order of such relative need.

Sec. 11. K. S. A. 1975 Supp. 65-420 is hereby amended to read as follows: 65-420. Applications for ~~hospital and medical facilities construction projects for which federal funds are requested~~ federal funds or loans for medical facility projects, except special project grants under section 1625 of public law 93-641 which shall be submitted directly to the federal secretary

of health, education and welfare, shall be submitted to the secretary and may be submitted by the state or any political subdivision thereof or by any public or other nonprofit agency [authorized to construct and operate a ~~hospital or a~~ medical facility~~, provided that no~~. No application for a diagnostic or treatment center shall be approved unless the applicant is (1) a state, political subdivision, or public agency, or (2) a corporation or association which owns and operates a nonprofit hospital.] Each application for ~~a construction~~ federal funds or loans for a medical facility project shall conform to federal and state requirements.

Sec. 12. K. S. A. 1975 Supp. 65-421 is hereby amended to read as follows: 65-421. The secretary shall afford to every applicant for ~~a construction~~ federal funds or loans for a medical facility project under K. S. A. 1975 Supp. 65-420, and any amendments thereto, an opportunity for a fair hearing. If the secretary, after affording reasonable opportunity for development and presentation of applications in the order of relative need, finds that a project application complies with the requirements of K. S. A. 1975 Supp. 65-420 and any amendments thereto, and is otherwise in conformity with the state plan ~~it~~, the secretary shall approve such application and shall ~~recommend and~~ forward ~~it to~~ the ~~surgeon general~~ application to the federal secretary of health, education and welfare along with such recommendation.

Sec. 13. K. S. A. 1975 Supp. 65-422 is hereby amended to read as follows: 65-422. ~~From time to time the~~ The secretary shall inspect each ~~construction~~ medical facility project approved by the ~~surgeon general,~~ federal secretary of health, education and welfare; and, if the inspection so warrants, the secretary shall certify to the ~~surgeon general~~ federal secretary of health, education and welfare that work has been performed upon the project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment of federal funds is due to the applicant.

Sec. 14. K. S. A. 1975 Supp. 65-423 is hereby amended to

read as follows: 65-423. The secretary is hereby authorized to receive federal funds in behalf of, and transmit them to, such applicants for federal funds or loans for medical facility projects approved by the federal secretary of health, education and welfare. There is hereby established, in the state treasury, ~~separate and apart from all public moneys and funds of this state,~~ a ~~hospital and~~ medical facilities ~~construction~~ project fund. Money received from the federal government for a ~~construction~~ medical facility project approved by the ~~surgeon general~~ federal secretary of health, education and welfare shall be deposited to the credit of this fund and shall be used solely for payments due ~~applicants~~ for work performed, or purchases made, in carrying out approved projects. Warrants for all payments from the ~~hospital and~~ medical facilities ~~construction~~ project fund shall bear the signature of the secretary or ~~his~~ the secretary's duly authorized agent for such purpose.

Sec. 15. K. S. A. 65-410, 65-416, 65-419 and K. S. A. 1975 Supp. 65-411, 65-412, 65-413, 65-414, 65-415, 65-417, 65-418, 65-420, 65-421, 65-422 and 65-423 are hereby repealed.

Sec. 16. This act shall take effect and be in force from and after its publication in the statute book.

Attachment 7

_____ BILL NO. _____

By Special Committee on Health and Human Resources

AN ACT abolishing the advisory hospital council; amending K. S. A. 65-430 and K. S. A. 1975 Supp. 65-431 and 65-438 and repealing the existing sections and also repealing K. S. A. 65-435 and K. S. A. 1975 Supp. 65-434.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K. S. A. 65-430 is hereby amended to read as follows: 65-430. The licensing agency after notice and opportunity for hearing to the applicant or licensee is authorized to deny, suspend or revoke a license in any case in which it finds that there has been a substantial failure to comply with the requirements established under this law. Such notice shall be effected by registered mail, or by personal service ~~setting forth~~ and shall state the particular reasons for the proposed action and ~~fixing~~ fix a date not less than thirty (30) days from the date of such mailing or personal service, at which the applicant or licensee shall be given an opportunity for a prompt and fair hearing. On the basis of any such hearing, or upon default of the applicant or licensee, the licensing agency shall make a determination specifying its findings of fact and conclusions of law.

A copy of such determination shall be sent by registered mail or served personally upon the applicant or licensee. The decision revoking, suspending or denying the license or application shall become final thirty (30) days after it is ~~so~~ mailed or served, unless the applicant or licensee~~, within such thirty day period, appeals the decision to the advisory council provided in section 10 of this act which shall convene within fifteen days after such appeal and may affirm, modify or reverse such decision or grant the licensee a period of time not exceeding one year in~~

~~which--the--licensee--shall-make-such-changes-as-are-necessary-to comply-with-the-requirements-established-under-this-act,--or--may grant--a--conditional--license--to--an-applicant-for-a-period-not exceeding-one-year-which-conditional-license-shall--automatically terminate--on--the--date-fixed-unless-the-applicant-shall,-before such-date,-comply-with-the-requirements--established--under--this act.---Any--decision--of--the-advisory-hospital-council-revoking, suspending,-or-denying-the-license-or--application--shall--become final-thirty-days-after-it-is-mailed-or-served,-unless-the-applicant--or--licensee~~ appeals as provided in ~~section-14-of-this-act~~ K. S. A. 1975 Supp. 65-438 and any amendments thereto.

The procedure governing hearings authorized by this section shall be in accordance with rules and regulations promulgated by the licensing agency ~~with-the-approval-of-the--advisory--hospital council.~~ A full and complete record shall be kept of all proceedings, and all testimony shall be reported but need not be transcribed unless the decision is appealed pursuant to ~~section 14-hereof~~ K. S. A. 1975 Supp. 65-438 and any amendments thereto. A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies. Witnesses may be subpoenaed by either party.

Sec. 2. K. S. A. 1975 Supp. 65-431 is hereby amended to read as follows: 65-431. The licensing agency ~~subject--to--the approval--of--the--advisory-hospital-council,~~ shall adopt, amend, promulgate and enforce such ~~rules,--regulations~~ rules and regulations and standards with respect to the different types of medical care facilities to be licensed hereunder as may be designed to further the accomplishment of the purposes of this law in promoting safe and adequate treatment of individuals in medical care facilities in the interest of public health, safety and welfare~~:-Provided,-That-no.~~ No rule or regulation shall be made by the licensing agency which would discriminate against any practitioner of the healing arts who is licensed to practice medicine and surgery in this state~~:--Provided--further,--That boards.~~ Boards of trustees or directors of facilities licensed

pursuant to the provisions of this act shall have the right to select the professional staff members of such facilities and to select and employ interns, nurses and other personnel, and no ~~rules, regulations~~ rules and regulations or standards of the licensing agency shall be valid which, if enforced, would interfere in such selection or employment~~: And provided further, That in~~. In formulating rules and regulations, the agency shall give due consideration to the size of the medical care facility, the type of service it is intended to render, the scope of such service and the financial resources in and the needs of the community which such facility serves.

Sec. 3. K. S. A. 1975 Supp. 65-438 is hereby amended to read as follows: 65-438. Any applicant or licensee aggrieved by the decision of the ~~advisory hospital council~~ licensing agency may appeal, within thirty (30) days after the mailing or serving of notice of the decision as provided in K. S. A. 65-430~~, or~~ and any amendments thereto~~, appeal~~ to the district court of the county in which the medical care facility is located or is to be located. The district court shall ~~try the appeal de novo and shall~~ have the jurisdiction to affirm, modify, vacate or reverse the decision ~~complained of~~ appealed. Notice of said appeal shall be filed in the office of the clerk of the district court, and a copy ~~thereof~~ served upon the licensing agency within five (5) days thereafter. Upon the filing of ~~said~~ the appeal, the licensing agency shall file, within twenty (20) days, ~~file~~ with the clerk of the district court all records of the licensing agency ~~and advisory hospital council~~ in the case, including the evidence taken at the proceedings. Either the applicant, licensee, licensing agent, or the state may apply for such further review as is provided by law in civil cases for appeals to the supreme court. Pending a final disposition of the matter, the status quo of the applicant or licensee shall be preserved except as the court otherwise orders ~~in the public interest~~.

Sec. 4. K. S. A. 65-430 and 65-435 and K. S. A. 1975 Supp. 65-431, 65-434 and 65-438 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

_____ BILL NO._____

By Special Committee on Health and Human Resources

Re Proposal No. 23

AN ACT relating to health planning and development; recognizing certain health planning and development agencies and providing for the composition, powers, duties and functions of such agencies; providing for preparation of a state health plan; repealing K. S. A. 65-193 and K. S. A. 1975 Supp. 65-190, 65-191, 65-192, 65-194, 65-195 and 65-196.

Be it enacted by the Legislature of the State of Kansas:

Section 1. This act shall be known and may be cited as the Kansas health planning and development act.

Sec. 2. As used in this act:

(a) "Provider of health care" means an individual:

(1) Who is a direct provider of health care (including a person licensed to practice medicine and surgery, licensed dentist, registered professional nurse, licensed practical nurse, registered podiatrist, or physician's assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including medical care facilities, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by state law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; or

(2) Who is an indirect provider of health care in that the individual:

(A) Holds a fiduciary position with, or has a fiduciary interest in, any entity described in subsection (a)(2)(B)(II) or subsection (a)(2)(B)(IV); or

(B) Receives, either directly or through his or her spouse, more than one-tenth of his or her 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 such research or instruction.

(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

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

(C) Is a member of the immediate family of an individual described in subsection (a)(1) or in subsection (a)(B)(I), (a)(B)(II) or (a)(B)(IV); or

(D) Is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(b) "Health resources" means health services, health professions, personnel, and health facilities, except that such term does not include Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(c) "Health facility" means medical care facility, psychiatric hospital, health maintenance organization, skilled nursing home, intermediate nursing care home, intermediate personal care home, home health agency, provider of outpatient physical therapy services including speech pathology services, except that such term shall not apply with respect to outpatient physical therapy services performed by a physical therapist in his or her office or in a patient's home, kidney disease treatment center, including centers not located in a medical care facility, health center and family planning clinic.

(d) "Health facility services" means the health services provided through health facilities and includes the entities

through which such services are provided.

(e) "Outpatient facility" means a medical facility (located in or apart from an inpatient health facility) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients) which:

(1) Is operated in connection with a hospital, in which patient care is under the professional supervision of persons licensed to practice medicine and surgery in the state, or in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the state; or

(2) Offers to patients not requiring hospitalization the services of persons licensed to practice medicine and surgery, and which provides to its patients a reasonably full range of diagnostic and treatment services.

(f) "Rehabilitation facility" means a health facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of:

(1) Medical evaluation and services, and

(2) Psychological, social, or vocational evaluation and services, under competent professional supervision; and in the case of which the major portion of the required evaluation and services is furnished within the facility; and either the facility is operated in connection with an inpatient health facility defined in subsection (c) or all medical and related health services are prescribed by or are under the general direction of persons licensed to practice medicine and surgery in the state.

(g) "Facility for long term care" means a health facility, including a skilled nursing or intermediate care facility, providing inpatient care for convalescent or chronic disease patients who require skilled nursing or intermediate care and related medical services (1) which is an inpatient health facility, other than an inpatient health facility primarily for the care and treatment of mentally ill or tuberculous patients or is operated in connection with an inpatient health facility, and (2)

in which such care and medical services are prescribed by, or are performed under the general direction of, persons licensed to practice medicine and surgery in the state.

(h) "Medical facility" means a medical care facility, public health center, outpatient medical facility, rehabilitation facility, facility for long-term care, or other facility, as the secretary may designate under public law 93-641, for the provision of health care to ambulatory patients.

(i) "State agency" means the secretary of health and environment.

(j) "Council" means the statewide health coordinating council created by section 5.

(k) "Health systems agency" means an agency designated under section 1515 of public law 93-641 (42 U.S.C. 3001-4) [and shall include health systems agencies conditionally designated under such section].

(l) "Secretary" means the secretary of the department of health, education and welfare of the United States.

(m) "Consumer of health care" means a person who has not been within twelve (12) months preceding appointment under this act a provider of health care.

Sec. 3. The state agency shall submit an application to the secretary containing assurances of authority and resources to administer a state administrative program. The state agency shall submit to the secretary for approval a state administrative program for the purpose of carrying out a certificate of need and a health planning and resources development function pursuant to public law 93-641.

Sec. 4. The functions of the state agency shall be:

(a) To conduct the health planning activities of the state and implement those parts of the state health plan and the plans of the health systems agencies within the state which relate to the government of the state.

(b) To prepare, and review and revise an annual preliminary state health plan which shall be based on the health systems

plans of the health systems agencies within the state. The preliminary state plan shall be submitted to the council for approval or disapproval and for use in developing the state health plan.

(c) To assist the council in the performance of its functions.

[(d) To serve as the designated planning agency of the state for administering state certificate of need programs which apply to health facility services proposed to be offered, developed or changed within the state.]

[(e) After consideration of recommendations submitted by health systems agencies respecting health facility services proposed to be offered or changed within the state, to make findings as to the need for such services, and, as appropriate, issue or deny a certificate of need.]

(f) To review on a periodic basis, but not less than every five (5) years, all health facility services being offered in the state and, after consideration of recommendations submitted by health systems agencies respecting the appropriateness of such services, make public its findings.

[(g) To prepare and administer the provisions of the state medical facilities plan as defined in section 1603 of public law 93-641.]

Sec. 5. In order to guide and promote health planning and resources development in response to enactment of section 1524 of public law 93-641 (42 U.S.C. 300m-3), there is hereby created a statewide health coordinating council.

(a) The council shall be composed of no more than twenty-seven (27) members. The majority of the members of this council shall be consumers of health care and not less than one-third of the members who are providers of health care shall be direct providers.

(b) The governor shall appoint not less than four (4) nor more than six (6) voting members from each health systems agency within the state from a list of at least seven (7) nominees from

each health systems agency who shall be residents of the state of Kansas. At least two (2) of the appointees from each health systems agency shall be consumers of health care. The governor shall appoint an equal number of members to the council from each health systems agency.

(c) In addition, the governor shall appoint the following voting members:

(1) The chairpersons of the public health and welfare committees of the senate and the house of representatives.

(2) Other persons, unless the number of members on the council equals the maximum number of members established by subsection (a), including those from the medically underserved population, and other representatives of governmental units within the state. The number of persons appointed under this subsection may not exceed forty percent (40%) of the total membership, and at least one-half of whom shall be consumers of health care.

(d) An individual designated by the chief medical director of the veterans' administration shall be a member.

(e) The council shall select its chairperson from among the membership of the council.

Sec. 6. The length of terms of the first members appointed by the governor, except members appointed pursuant to paragraph (1) of subsection (c) of section 5 shall conform, as near as possible, to the following requirements: One-third for four (4) years, one-third for three (3) years, and one-third for two (2) years. Initial appointments shall be made within three (3) months of the designation of the health systems agencies. Subsequent appointments shall be for terms of four (4) years, except an appointment to fill a vacancy shall be for the balance of the unexpired term. Members appointed pursuant to paragraph (1) of subsection (c) of section 5 shall serve during the period of time such member serves as chairperson of a committee referred to in such paragraph.

Sec. 7. (a) The council shall meet at least quarterly and as often as necessary to fulfill its duties.

(b) Meetings and records of the council shall be open to the public.

(c) All meetings of the council shall be held in Topeka.

Sec. 8. The members of the council attending meetings of such council, or attending a subcommittee meeting thereof authorized by such council, shall be paid compensation, subsistence allowances, mileage and other expenses as provided in K. S. A. 1975 Supp. 75-3223, or amendments thereto.

Sec. 9. The functions of the council shall be:

(a) To annually review and coordinate the health system plan and annual implementation plan of each health systems agency within the state and report its comments to the secretary.

(b) Guide the state agency in the development of procedures and criteria to be used for integration of the health systems plans into a preliminary state health plan.

(c) Annually prepare, review and revise with the assistance of the state agency the state health plan. In preparing and revising the state health plan, the council shall review and consider the preliminary health plan submitted by the state agency. The council shall conduct a public hearing on the proposed state health plan and shall give interested persons an opportunity to submit their views orally and in writing. Thirty (30) days prior to such hearing the council shall publish notice of its consideration of the proposed plan in at least two (2) newspapers of general circulation in the state. The notice shall include the time and place of the hearing, the place or places at which copies of the proposed plan are available for review and the period during which written comments may be submitted to the council.

(d) Review annually the budget of each health systems agency and report its comments to the secretary.

(e) Recommend a uniform format and methodology for the development of a health systems plan to facilitate incorporation into a preliminary state health plan.

[(f) Advise and consult with the state agency in carrying out the state medical facilities plan.]

(g) Review applications submitted by health systems agencies for grants under section 1516, operational grants, and section 1640, area health service development fund grants, of public law 93-641 (42 U.S.C. 3001-5 and 42 U.S.C. 300t) and report its comments to the secretary.

(h) Advise the state agency on the performance of its functions and in the establishing of priorities.

(i) Review annually and approve or disapprove any state plan or any application submitted to the secretary as a condition to the receipt of any funds under allotments made to states under public law 93-641, the community mental health centers act (42 U.S.C. 2681) or the comprehensive alcohol abuse and alcoholism prevention, treatment and rehabilitation act of 1970 (42 U.S.C. 4571).

Sec. 10. In conformance with public law 93-641, there is created in each health service area a health systems agency for local health planning and development activities. The health systems agencies shall be those agencies that have entered into agreement with the secretary in accordance with the requirements of section 1515 of public law 93-641 (42 U.S.C. 3001-4).

Sec. 11. (a) A health systems agency for a health service area shall be a nonprofit private 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 health systems agency shall not be an educational institution or operate such an institution.

Sec. 12. A health systems agency shall have a governing body composed, in accordance with section 13, of not less than ten (10) members and not more than thirty (30) members, except that the number of members may exceed thirty (30) if the governing body has established an executive committee composed of not more than twenty-five (25) members of the governing body and

has delegated to that executive committee the authority to take action other than the establishment and revision of the health systems plans and annual implementation plans.

Sec. 13. The members of the governing body or the executive committee of a health systems agency shall meet the following requirements:

(a) A majority, but not more than sixty percent (60%) of the members shall be residents of the health service area served by the entity who are consumers of health care and who are broadly representative of the social, economic, linguistic and racial populations, geographic areas of the health service area, and major purchasers of health care.

(b) The remainder of the members shall be residents of the health service area served by the agency who are providers of health care and who represent (1) physicians, particularly practicing physicians, dentists, nurses and other health professionals, (2) health facilities, particularly medical care facilities, long-term care facilities and health maintenance organizations, (3) health care insurers, (4) health professional schools and (5) the allied health professionals. 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.

(c) The membership shall (1) include, either through consumer or provider members, public elected officials and other representatives of governmental authorities in the health systems agency's health service area and representatives of public and private agencies in the area concerned with health, (2) include a percentage of individuals who reside in nonmetropolitan areas within the health service area of which the percentage is equal to the percentage of residents of the area who reside in nonmetropolitan areas, and (3) 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 health maintenance organizations, include at least one member who is representative of such organization.

(d) 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 make its appointments to any such subcommittee or groups in such a manner as to provide approximately the representation of such subcommittee or group described in this section.

Sec. 14. (a) The governing body (1) shall be responsible for the internal affairs of the health systems agency, including matters relating to the staff of the agency, the agency's budget, and procedures and criteria applicable to its functions; (2) shall be responsible for the establishment of the health systems plan and annual implementation plan; (3) shall be responsible for the approval of grants and contracts made and entered into under section 21 concerning functions; (4) shall be responsible for the approval of all actions taken pursuant to sections 26 and 27; (5) shall (A) issue an annual report concerning the activities of the agency, (B) include in that report the health systems plan and annual implementation plan developed by the agency and a listing of the agency's income, expenditure assets, and liabilities, and (C) make the report readily available to the residents of the health service area and the various communication media serving such area; and (D) shall reimburse its members for their reasonable costs incurred in attending meetings of the governing body; (6) shall meet at least once in each calendar quarter of a year and shall meet at least two (2) additional times in a year unless its executive committee meets at least two (2) times in that year; and (7) shall (A) conduct its business meetings in public, (B) give adequate notice to the public of such meetings, and (C) make its records and data available upon request to the public.

(b) The governing body and the executive committee, if an executive committee has been established, of a health systems agency shall act only by vote of a majority of its members present and voting at a meeting called upon adequate notice to all of its members and at which a quorum is present. A quorum for a governing body and executive committee shall not be less than one-half of its members.

Sec. 15. (a) A health systems agency shall have a staff which provides the agency with expertise in at least the following: (1) administration, (2) the gathering and analysis of data, (3) health planning, and (4) development and use of health resources. The functions of planning and of development of health resources shall be conducted by staffs with skills appropriate to each function. The size of the professional staff of any health systems agency shall not be less than five (5), except that if the quotient of the population, rounded to the next highest one hundred thousand (100,000) of the health service area which the agency serves divided by one hundred thousand (100,000) is greater than five (5), the minimum size of the professional staff shall be the lesser of (1) such quotient or (2) twenty-five (25). The members of the staff shall be selected, paid, promoted and discharged in accordance with such systems as the agency may establish, except that the rate of pay for any position shall not be less than the rate of pay prevailing in the health service area for similar positions in other public or private health service entities.

(b) If necessary for the performance of its functions, a health systems agency may employ consultants and may contract with individuals and entities for the provision of services. The responsibility for plan development, review and comment rests with the health systems agency.

Sec. 16. No individual, as a member or employee of a health systems agency, by reason of his or her performance of any duty, function or activity required or authorized to be undertaken by the health systems agency under this act, shall be liable in a

civil action for the payment of damages under any law of this state or political subdivision thereof, if he or she has acted within the scope of such duty, function or activity, has exercised due care and has acted, with respect to that performance, without malice.

Sec. 17. No health systems agency may accept any funds or contributions of services 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, unless, in the case of an entity, it is an organization described in section 509(a) of the internal revenue code of 1954 (26 U.S.C. 509) and is not directly engaged in the provision of health care in the health service area of the agency. For the purpose of this section, 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.

Sec. 18. Each health systems agency shall:

(a) Make such reports, in such form and containing such information, concerning its structure, operation, performance of functions and other matters that may be from time to time required, and keep such records and afford such access to the secretary and the council in compliance with the provisions of this act and public law 93-641.

(b) Provide for such fiscal control and fund accounting procedures as may be required to assure proper disbursement of and accounting for amounts received to the council under the general provisions of this act and public law 93-641 concerning planning and development grants.

(c) Permit state and federal representatives to have access for the purpose of audit and examinations to any books, documents, papers, and records pertinent to the disposition of amounts received under the general provisions of this act and public law 93-641.

Sec. 19. A health systems agency may establish subarea advisory councils representing parts of the agency's health

service area to advise the governing body of the agency on the performance of its functions. The composition of a subarea advisory council shall conform to the requirements of sections 12 and 13.

Sec. 20. Each health systems agency for the purpose of (a) improving the health of residents of a health service area, (b) increasing the accessibility, including overcoming geographic, architectural and transportation barriers, acceptability, continuity and quality of the health services provided the residents, (c) restraining increases in the cost of providing them health services and, (d) preventing unnecessary duplication of health resources shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health service, manpower and facilities which meet identified needs, reduce documented inefficiencies and implement the health plans of the health systems agency.

Sec. 21. (a) In providing health planning and resources development for its health service areas, a health systems agency shall:

(1) Assemble and analyze data concerning the status and its determinants of the health of the residents of its health service area.

(2) Analyze the status of the health care delivery systems in the area and the use of that system by the residents of the area.

(3) Analyze the effect of the area's health care delivery system on the health of the residents of the area.

(4) Analyze the number, type, and location of the area's health resources, including health services, manpower, and facilities.

(5) Analyze the pattern of utilization of the area's health resources.

(6) Analyze the environmental and occupational exposure factors affecting immediate and long-term health conditions.

(b) In performing the function authorized by this section, the agency shall use existing data and coordinate its activities with the cooperative system provided for under section 306(e) of the public health services act (42 U.S.C. 242d).

Sec. 22. (a) Health systems agencies, after consideration of national health guidelines, shall establish, annually review and amend as necessary a health systems plan. The health systems plan shall include a description of a healthful environment and a health system directed toward achieving quality health services which are available, accessible, of reasonable cost, responsive to the unique health needs and resources of the area and which assures continuity of care to residents of the area. Health systems plans shall be submitted to the state agency annually.

(b) Before establishing or amending a health systems plan, a health systems agency shall conduct a public hearing on the proposed plan or amendments and shall give interested persons an opportunity to submit their views orally and in writing. Thirty (30) days prior to such hearing the health systems agency shall publish notice of its consideration of the proposed plan or amendments in at least two (2) newspapers of general circulation in the health service area. The notice shall include the time and place of the hearing, the place at which copies of the proposed plan or amendments are available for review and the period during which written comments may be submitted to the health systems agency.

Sec. 23. Health systems agencies after consideration of goals developed in the health systems plan shall establish, annually review and amend as necessary an annual implementation plan which describes objectives and priorities to achieve these goals. The priorities shall be based upon the maximum improvement of the health of the residents in the health service area in relation to the cost involved, the benefits obtained and the special needs of the area. The annual implementation plan shall be forwarded to the state agency and the council each year.

Sec. 24. In accordance with the priorities established in

the annual implementation plan, a health systems agency shall make grants to public and nonprofit private entities and enter into contracts with 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 health system plan, if the health systems agency has entered into a full designation agreement with the secretary. Such grants and contracts shall be made from the area health services development fund of the agency established with funds provided under grants made under section 1640 of public law 93-641 (42 U.S.C. 300t). No grant or contract under this section may be used to pay the cost incurred by an entity or individual in the delivery of health services or for the cost of construction or modernization of medical facilities. No single grant or contract made or entered into under this section 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 section for a project or program, such individual or entity may receive only one more grant or contract for such project or program.

Sec. 25. Each health systems agency shall coordinate its activities with the following: (a) each professional standards review organization designated under section 1152 of public law 92-603 (42 U.S.C. 1320c-1), amendments to the social security act; (b) entities referred to in paragraphs (1) and (2) of section 204(a) of the demonstration cities and metropolitan development act of 1966 (42 U.S.C. 3334) and regional and local entities the views of which are required to be considered under regulation prescribed under section 403 of the intergovernmental cooperation act of 1968 (42 U.S.C. 4233) to carry out section 401(b) of such act (42 U.S.C. 4231); (c) other appropriate general or special purpose regional planning and administrative agencies; and (d) any other appropriate entity in the health systems agencies' health service area. The health systems

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

Sec. 26. (a) Each health systems agency shall review and approve or disapprove each proposed use within its health service area of federal funds appropriated under the public health service act, as amended by public law 93-641, the community mental health centers act (42 U.S.C. 2681), the comprehensive alcohol abuse and alcoholism prevention, treatment and rehabilitation act of 1970 (42 U.S.C. 4571), for grants, contracts, loans or loan guarantees for the development, expansion or support of health resources, if the health systems agency has been authorized by the secretary to perform such a function.

(b) A health systems agency authorized by the secretary to perform the function stated in subsection (a) shall not review and approve or disapprove the proposed use within its health services area of federal funds appropriated for grants or contracts under title IV, VII, or VIII of the public health services act (42 U.S.C. 281 et seq., 42 U.S.C. 292 et seq. and 42 U.S.C. 296 et seq.), 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 systems agency of federal funds described in this section by an Indian tribe or intertribal Indian organization for any program or project which will be located within or will specifically serve a federally reorganized Indian reservation, a health systems agency shall only review and comment on such proposed use.

(c). Each health systems agency shall provide each Indian tribe or intertribal Indian organization which is located within the agency's health service area information respecting the availability of the federal funds described in this section.

Sec. 27. (a) Each health systems agency shall review on a periodic basis, but at least every five (5) years, all health facility services offered in its health service area and shall make recommendations to the state agency with respect to the appropriateness of such services. A health systems agency shall complete its initial review of existing health facility services within three (3) years after the health systems agency has been authorized by the secretary to conduct such review.

(b) Each health systems agency authorized by the secretary to conduct a review under subsection (a) shall review and make recommendations to the state agency with respect to the need for new health facility services to be offered or developed in the health service area of such health systems agency. Each health systems agency shall submit its findings to the council for purposes of review.

Sec. 28. Each health systems agency authorized by the secretary to make the recommendations contemplated by this section shall annually recommend to the state agency:

(a) Projects for the modernization, construction and conversion of medical facilities in the agency's health service area which projects will achieve the health systems plan and annual implementation plan of the health systems agency, and

(b) Priorities among such projects.

Sec. 29. A health systems agency shall submit annually to the council the budget for purposes of review and approval; and all applications for planning and development grants, and area health services development funds, for purpose of review.

Sec. 30. The district court shall have jurisdiction to enjoin a health systems agency from transacting the business of or performing any functions of a health systems agency in this state, if such health systems agency has failed to comply with

any provision of this act, applicable to it or has abused, misused or failed to use the powers, privileges and functions granted to such health systems agency under this act. The attorney general upon the relation of the state agency or the council shall proceed for this purpose by an action commenced in the district court of any county which is part of the health service area of the health systems agency.

[Sec. 31. Each health systems agency shall review and make recommendations to the state agency on application for certificate of need submitted for entities within its health service area.]

Sec. 32. K. S. A. 65-193 and K. S. A. 1975 Supp. 65-190, 65-191, 65-192, 65-194, 65-195 and 65-196 are hereby repealed.

Sec. 33. This act shall take effect and be in force from and after its publication in the statute book.

structure which is or could be utilized for the delivery of public health services.

Draft

c

COMMITTEE REPORT

TO: Legislative Coordinating Council

FROM: Special Committee on Health and Human Resources

SUBJECT: Proposal No. 22 - Delivery of Health and Environmental Services

Proposal No. 22 directed a study of the roles of the city, county, state and federal governments in the funding and delivery of public health and environmental services, including an evaluation of the quality and adequacy of such services. The study was also to include consideration of regionalization for the delivery of such services and a review of state statutes relating to local boards of health, local health officers and local health departments.

Public Health and Environmental Services

In order to obtain information about the quantity and quality of personal and environmental health services being provided at the local level, the Committee invited each county health officer and each board of county commissioners or joint board of health in the state to meet with the Committee. Approximately _____ health officers or their representatives made personal presentations. Written responses were received from _____ others. In addition _____ representatives of county or joint boards of health appeared before the Committee or sent written comments to the Committee. The conferees outlined the health-related services now provided by local health agencies, expressed their views on the type of services which should be provided, and commented on the governmental

While it was recognized that there are areas in the state in which locally delivered public health services are not available, many of the conferees expressed opposition to mandating a minimum level of service to be provided by local health departments without further study and input from local officials. Concern was expressed that mandated services would not be tailored to the needs of the area to be served. Many conferees did, however, indicate that environmental health services are not adequate at the local level.

Under Kansas statutes, each of the 105 counties in Kansas must have a health officer or, in those counties of less than 100,000 population, a local health program administrator with a doctor or dentist designated as a consultant. An exception to this requirement is the situation in which two or more counties have joined to form a multicounty health department. In each of the counties of the state the board of county commissioners serves as the county board of health except in those instances in which counties or a county and city have joined together to create joint boards of health.

At the present, 83 counties in Kansas have some form of organized health department. Eight of these have combined city-county departments and ten have joined with other counties to form multicounty units. According to the tax levies published by the individual counties, 31 counties made no specific tax levy for health services for the current tax year.

The majority of the organized health departments are staffed by a part-time health officer, one or more community health nurses and a clerk. Twenty-two also have one or more sanitarians. Wyandotte, Sedgwick and Shawnee Counties have large city-county health departments directed by full-time medical directors and employ a variety of specialized health personnel.

Regionalization of Public Health Services

Recognizing that all areas of the state are not served by public health departments and that the population and needs of some counties are not sufficient to support a range of such services, various citizen committees and a 1971 special legislative committee have recommended that the delivery of such services be carried out by public health regions.

Recommendations for the creation of public health regions have been based on the premise that all Kansas citizens should have access to public health services regardless of where they live, the belief that a minimum population and tax base is necessary for the most economic and efficient delivery of such services, and recognition of the need to make the most efficient use of health personnel. All recommendations have included state financial assistance for regional public health agencies.

While many conferees who met with the Committee recognized the advantages of the concept of regional organization for the delivery of public health and environmental services, there was no agreement on whether regions should be mandated by statute nor on the details of creating a governing body, funding, etc. There was almost unanimous agreement that additional study should be carried out prior to any mandatory reorganization. It was noted that when the first citizens' study committee recommended regionalization in 1965 there were 87 counties in Kansas with no organized health departments. In the decade since, there have been locally initiated efforts to develop organized health departments and a trend toward a multicounty public health delivery structure.

Statutory Revision

Under the directive of Proposal No. 22, the Committee reviewed those statutes which relate to local boards and departments of health. It was found that the terminology used in such statutes is far from uniform and leads to confusion in that the statutory references do not always clearly indicate that such references are to/county boards of health and health officers mandated by law.

In the course of its study, the Committee also considered recommendations of the Department of Health and Environment for updating certain statutes to reflect current practice or terminology. In some instances, the Committee concluded that a change in the policy reflected in the statutes is desirable.

The recommendations for statutory change arising from Committee study are embodied in three bills which the Committee has prepared. The major provisions of the bills are summarized below.

Recommended Legislation

As a result of study pursuant to Proposal No. 22, the Committee has prepared three bills for consideration by the 1976 Legislature.

_____ Bill (1615) would revise a number of statutes in which there is a reference to health officers, departments of health, boards of health or similar terms. The Committee found that the terminology in these statutes is not uniform since they were enacted over a period of years. Therefore, the majority of the proposed amendments in _____ Bill (1615) are for the purpose of making

the terminology uniform. For clarity, statutory references to health officer are changed to local health officer, references to health departments are changed to county, city-county or multicounty health departments, and references to boards of health are changed to county or joint boards of health. As a result of the proposed amendments it would be clear that all references are to county agencies or officials unless otherwise specified. Other technical amendments are included in the bill.

_____ Bill (1615) also includes policy changes.

Amendments to K.S.A. 23-310 (Section 7) would leave the method of destruction of premarital examination certificates to the discretion of the probate court and shorten the period of time they must be retained by the court from five to two years.

Changes in K.S.A. 1975 Supp. 23-501 (Section 8) would delete any reference to age in the statute which authorizes the provision of family planning information and services.

Proposed amendments to K.S.A. 1975 Supp. 39-930 contained in Section 12 of _____ Bill (1615) would raise the amount of the adult care home license fee forwarded to county, city-county or multicounty health departments from 40 to 80 percent when the local agency makes the licensing evaluation and inspection for the state.

Section 22 and new Section 23 would result in separating the provisions of K.S.A. 1975 Supp. 65-159 which gives authority to the Secretary of Health and Environment and boards of health to order the removal of sources of filth or sickness and health nuisances. The policy change reflected in two sections relates to the penalty for failure to abate a health nuisance after an order has been issued.

Additions to K.S.A. 1975 Supp. 65-202 as they appear in Section 29 would require local health officers to send copies of school inspection reports to the Secretary of Health and Environment and the governing body of the school. This amendment supplements the provisions of _____ Bill (1648) also being recommended by the Committee.

Section 31 of _____ Bill (1615) would amend K.S.A. 1975 Supp. 65-220 to change the definition of community nursing services.

_____ Bill (1648), as prepared by the Committee, would authorize the Secretary of Health and Environment to establish and enforce standards for the inspection of schools for health purposes. A procedure under which the Secretary could order that any condition in violation of the health standards be corrected is set forth in the bill.

_____ Bill (1646) would amend several statutes which relate to infections or contagious diseases. The amendatory language specifies those persons required to report such disease, adds child care facilities to the list of institutions required to exclude persons having an infectious or contagious disease, and clarifies the definition of such diseases to be those defined by rules and regulations adopted by the Secretary of Health and Environment. Other changes are primarily technical in nature.

Conclusions and Recommendations

The Special Committee on Health and Human Resources considered the establishment of mandatory minimum locally delivered public health services either by statute or pursuant to minimum standards to be adopted by the Secretary of Health and Environment.

In reaching their conclusion, the members considered the right of all Kansans to have public health and environmental services available to the local level rather than having to travel to those areas where such services are provided. It was also noted that in those areas not presently served by organized health departments, people may not be fully aware of the type of services such a department could provide or know how to go about making their needs known. Required minimum services could be so phased that the counties could plan funding and secure personnel over a period of time.

The Committee members also determined that there is sufficient statutory authority for counties to provide public health services through the organization of a single or multicounty health department when the need for services is recognized. The State Department of Health and Environment can exert leadership in working with underserved local areas to develop public health services.

Moreover, the planning and study which will be carried out by designated health systems agencies pursuant to PL 93-641 (see report on Proposal No. 23) should lead to more awareness of the type of services which health departments provide and allow consumers and providers to determine the needs of their health service areas and to plan for delivery of such services by public agencies and private providers.

The Committee has concluded that no minimum public health and environmental services should be mandated at the local level at the present time.

After discussion of previous studies and testimony relating to state mandated regions for the delivery of public health and environmental services, the members of the Special Committee on Health and Human Resources decided not to recommend introduction

of legislation which would implement the concept of regionalization. Realizing the potential impact of new federal legislation relating to health planning and resource development studied by the Committee under another proposal, the Committee also concluded that bills relating to regionalization held over from the 1975 Legislature should not be reported favorably by the standing committees to which they are assigned.

The Committee does recommend that the three bills introduced by the Committee be enacted by the 1976 Legislature.

Respectfully submitted,

_____, 1975

Representative Richard Walker, Chairman
Special Committee on Health and Human Resources