Approved Stephen R. Cloud 2-3-83
Date

MINUTES OF THE HOUSE COMMITTEE ON GOVERNMENTAL ORGANIZATION.

The meeting was called to order by Representative Stephen R. Cloud at
Chairperson

9:04 a.m./~~p.m.~~ on Tuesday, January 25, 1983 in room 522-S of the Capitol.

All members were present except:

Committee staff present:

Avis Swartzman - Revisor
Carolyn Rampey - Research Dept.
Russ Mills - Research Dept.
Jackie Breymeyer - Secretary

Conferees appearing before the committee:

Emalene Correll - Legislative Research
Guillermo Barreto-Vega - Executive Director, Health Systems Agency of NE KS
Randy Hays - Staff Member, Health Systems Agency of SE KS
Jerry Slaughter - Kansas Medical Society
Barbara Sabol - Secretary, Kansas Department of Health and Environment

Chairman Cloud called the meeting to order at 9:04 a.m. The minutes of the previous meeting were approved. Memorandums from the Legislative Research Department included: Options in Health Planning, Background in Health Planning and Board of Healing Arts. (Attachments I, II and III).

The Chairman stated that the Committee would now be taking up HB 2013, which is a middle bill of a three bill package, HB 2012, HB 2013 and HB 2014, contained in Proposal 27. He introduced Emalene Correll, Research Department, who gave a report on the bill dealing with the expiration of the Kansas health planning and development act. She went through and explained the various sections of the memos on Options and Background in Health Planning. She went into detail concerning the Certificate of Need process and answered several Committee questions. Chairman Cloud thanked Ms. Correll for her presentation.

Next on the list of conferees was Guillermo Barreto-Vega, Executive Director, Health Systems Agency of NE KS. He spoke in favor of the bill, citing the positive support for the Health Planning Program at the National level. He said an extension will enable a planning commission to study the program and submit recommendations to the Governor and Legislature. (Attachment IV)

Randy Hays, staff member, Health Systems Agency of SE KS, read from his prepared statement, ending with the statement that we can all work together at the local, state and national levels to help promote Local Health Planning. (See Attachment V)

Mr. Jerry Slaughter, Kansas Medical Society identified himself and the organization he represents and said he would be available for any questions or help if the members desired it. He stated support for the bill.

Barbara Sabol, Secretary, Kansas Department of Health and Environment, distributed her statement to the Committee and gave the official position taken by the department she heads as secretary to HB 2013. She said that in 1983 it is expected that Congress will probably design a new program, or, phase out the existing program. Therefore the Department's position is to recommend that HB 2013 be passed. (See Attachment VI)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE HOUSE COMMITTEE ON GOVERNMENTAL ORGANIZATION,

room 522-S, Statehouse, at 9:04 a.m./~~p.m.~~ on Tuesday, January 25, 1983

Subcommittee assignments were passed out, along with minutes of the January 21 meeting and motor vehicle procedures in regard to titles and tags.

Chairman Cloud asked Committee members to read over their memorandum on the Board of Healing Arts.

It was announced that the subcommittee chairpersons will meet with their subcommittees tomorrow, January 26, 9:00 a.m. Chairperson Fuller's subcommittee will meet in Room 522-S, Chairperson Hassler's subcommittee will meet in the 5th Floor East Lounge and Chairperson Louis' subcommittee in the 5th Floor West Lounge. These meetings and locations will be published in Wednesday's Calendar. The subcommittee chairpersons were asked to meet with Chairman Cloud to give him their itinerary for Friday and/or next week. The deadline for the Committee Agenda is 12:00 noon.

Several points relating to subcommittee work were brought to the attention of the Committee by the Chairman. If for some reason the subcommittee dealing with a certain issue does not unanimously agree, a verbal or written minority report may be brought before the whole Committee.

Several Senate bills dealing with extending various agencies will be coming to our Committee. We can pass these through or amend these bills with our recommended changes and then send them back to the Senate.

Every point that the Post Audit brought up as a recommendation should be addressed. If the subcommittees dealing with these recommendations do or do not concur, the Committee should be told why. If the subcommittees get as far as needing proposed legislation then they should get with Avis Swartzman, Revisor, to have a draft made. This can then be brought to the whole Committee for presentation. If the Committee agrees to have it entered as a bill, it will be up to the Speaker to refer it to the Committee he wishes. We would request that it be brought back to this Committee.

The Rules and Regulations Committee could handle some areas not needing proposed legislation but one of the pitfalls of this procedure would be that we would lose control of these and nothing would be done with them until next summer.

Simply invoking change in policy by the agency and the Committee coming to an agreement would be another solution. A letter from the Secretary of the Department showing that he concurs in this change would be put on file. If change would not be implemented, the agency would be contacted.

Keep in mind that the entire agency is up for review.

The Alcohol Beverage Control Division will have a hearing in the old Supreme Court Chambers on Thursday, January 27 at 10:00. Mr. Tom Kennedy, Director, has invited our ABC subcommittee, the Senate Federal & State Affairs subcommittee, members of the liquor industry and others to attend. Discussion will center on minimum price mark-ups.

The Chairman urged the subcommittee chairpersons to keep him informed of what will take place at their meetings. If the subcommittees are going on site or having conferees in to speak, please keep the office informed.

The meeting was adjourend at 10:17 a.m.

GUEST LIST

COMMITTEE: GOVERNMENTAL ORGANIZATION DATE: 1/25/83

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATION |
|---|---|---|
| BARBARA J. SABOL | Topeka | KDH&E |
| Tammy Johnson | Topeka | Intern |
| Joe Kimbell Oswalt | | KDH&E |
| [illegible] | Topeka | KS Gen. Society |
| Guillermo Benito-Vega | Topeka | HSANEK |
| Rebecca Kupper | Topeka | KHA |
| HAROLD RIEMAN | TOPEKA | KS. OSTEOPATHIC ASSN |

GUEST LIST

COMMITTEE: GOVERNMENTAL ORGANIZATION DATE: 1/25/83

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATION |
|---|---|---|
| Ed Reinert | Topeka | KS League Women Voters<br>KS Sierra Club |
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CONFEREES

BILL NO. 2013

SUBJECT Concerning the expiration of the Kansas health planning and development act (Re Proposal No. 27 from special committee on Public Health and Welfare)

DATE OF HEARING 1/25/83

SPONSOR

| DATE NOTIFIED | NAME | ORGANIZATION | ADDRESS | PHONE | TESTIFY? |
|---|---|---|---|---|---|
| 1/19/83 | Emalene Correll | Legislative Research | Capitol Bldg. | 296-3181 | Yes |
| 1/21/83 | Guillermo Barreto-Vega | Health Systems Agency Northeast Kansas | | 233-3385 | Yes |
| 1/21/83 | Randy Hays | Health Systems Agency Southeast Kansas | | (316) 264-2861 | Yes |
| 1/21/83 | Jerry Slaughter | Kansas Medical Society | | 233-4512 | Yes |
| 1/21/83 | ~~Dick Morrissey~~ Barbara Sabol | Ks. Dept. of Health and Environment | Bldg.#740 Forbes | | Yes |
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MEMORANDUM

November 4, 1982

TO: Special Committee on Public Health and Welfare

FROM: Kansas Legislative Research Department

RE: Background of Health Planning

Many persons assume that the current formal structure through which health planning is carried out and health planning itself, are a relatively new concept, both in the United States and in Kansas. In fact, although legislative involvement in the creation of the structure through which health planning is carried out, i.e., the health systems agency (HSA), the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC) is relatively recent, health planning has roots that date back over the past five decades and the current health planning structure has, at least in part, evolved from local and state health planning activities that span the years following the end of World War I to the present.

It seems appropriate to review the history and evolution of health planning as a part of any study of the future of health planning for at least two reasons. First, a lack of knowledge about the history of health planning and its evolution on several levels can lead to a perception of health planning solely as a new concept forced on the states by the federal government within the last decade. Second, it seems reasonable to look at the history of health planning to discover whether there are lessons that can be learned from the past that have meaning in any discussion of the future role of health planning in Kansas.

Health planning has evolved over the last 50 years on several levels.

One such level is private sector planning encompassing the planning efforts of individual health institutions, agencies, or providers. Private sector health planning predates the development of community health planning structure and continues into the 1980s, sometimes isolated from community and regional planning for health and sometimes coordinated with other health planning.

Voluntary community planning, a second level of health planning, can be traced historically to the period immediately following World War I when community councils of social agencies or local health and welfare federations were created in urban communities. Since many health and welfare services were provided through community organizations and voluntary agencies rather than governmental entities, professionals and community leaders saw a need to develop local forums in which information could be exchanged and the activities of voluntary health and welfare agencies could be coordinated. Councils of social agencies or local health and welfare federations or coalitions developed planning capabilities when joint community charitable fund raising replaced individual charity as the source of funding for voluntary community agencies. As the concept of the "community chest" spread across the country in the 1920s and 1930s, community leaders saw that it was necessary to identify the needs of the community and to determine priorities for funding. Thus, planning for community health and welfare services began at the level of the individual community

on a voluntary basis. Voluntary planning on the community level developed at different times and took different forms as it was adapted to the needs of individual communities in the 1930s and early 1940s. In Kansas, the earliest formal voluntary community health and welfare planning structures developed in the more urban areas of the state. Less formally structured planning adapted to community needs were developed in smaller communities.

Although the early voluntary community planning efforts took diverse forms, they usually had several common characteristics. One, the voluntary community health and welfare planning structure was primarily concerned with the allocation of resources and the effective delivery of service. Second, planning was most often related to the allocation of charitable funds raised in the community, not with the allocation of governmental funding. Third, the community structure or agency usually included the principal contributers of charity funds and community health professionals, but seldom involved institutional health care providers, such as hospitals, in either coordinated community fund raising or planning and resource allocation. Indeed, by the later 1940s when hospitals begain to need great amounts of funding to replace capital expenditures that had been foregone during the depression years of the 1930s and the war years of the 1940s, separate voluntary community planning structures in the form of hospital or health facilities planning agencies or councils were created in some of the major metropolitan areas of the country.

In 1946, the federal Hospital Survey and Construction Act (Hill-Burton Act) was enacted. Along with federal financial assistance for the construction of health facilities came state involvement in health planning. Under the Hill-Burton Act, each state was required, as a condition to participating in the federal grants available for health facility construction, to survey its hospital system and prepare a plan for remedying any deficiencies that were found in the system. Thus, the individual states had to become involved in health facility planning. Grants for individual hospital construction were provided in accordance with a state plan developed by a designated state agency which had to project health facility needs, set priorities, and coordinate the development of various types of health facilities. The federal act also required an agency of the state to monitor health facility construction costs and to enforce construction standards. Kansas enacted the Kansas Medical Facilities Survey and Construction Act, K.S.A. 65-410 through 65-424, in 1947.

The backlog in health facility expansion, renovation, and construction that gave rise to the Hill-Burton Act also stimulated the creation of voluntary community hospital review councils or agencies at the community level during the 1940s and 1950s, including the voluntary hospital planning councils that were created in some Kansas communities. Some of the community health facilities councils or agencies included health professionals in the planning and decision making process; others did not. Some combined joint fund raising and planning efforts. Although as the community organizations developed, planning and fund raising tended to be separated because joint fund raising in a community with several hospitals involved large sums of money. In some areas, community hospital councils saw their primary function as reviewing the need for health facility construction and restricting such construction, along with planning to avoid the duplication of health facility services.

Over the years, many of the community health facility councils evolved to include more community representation on their governing boards; to expand their concerns to include long-term care, ambulatory care, health manpower, etc.; to include

facility programs in their planning efforts as well as facilities; and to establish various types of relationships with Blue Cross-Blue Shield and other public and private agencies. However, on the local level, planning for health facilities was most often separated from planning for other health services.

The federal Community Health Services and Facilities Act of 1961 established a new federal policy of financial support for community hospital review and planning councils by authorizing grants to be made under Section 318 of the Public Health Service Act to assist nonprofit organizations to set up community health facility planning bodies. Under the 1961 federal legislation the major difference between the "318" health facility planning agencies and their predecessor voluntary community councils was federal funding. Neither type of community planning entity could enforce compliance with the facility's plans that were developed, except as they could influence private charitable contributions to health facilities.

Although the next specific federal health planning legislation was not enacted until 1966, there were three federal acts adopted in the period between 1961 and 1966 which contributed policies to the evolution of health planning. The Community Mental Health Center Act of 1963, the Community Mental Retardation Center Act of 1964, and the Comprehensive Rehabilitation Act of 1965 each delegated planning and administrative responsibilities to the states; each required comprehensive statewide program planning, as distinguished from facilities planning; and each emphasized a coordinated systems of services. These acts were significant in the evolution of health planning because they fragmented health planning and gave local interest groups a way to avoid local attempts to coordinate health functions and services at the local level.

Two other federal programs that were initiated in the 1960s contributed new concepts in planning which became a part of the current health planning structure. The programs funded by the Office of Economic Opportunity (OEO), which was established in 1964, were structured to by-pass local institutional structures including local political bodies; stimulated the development of neighborhood health centers and new types of health workers; and emphasized maximum participation by the people being served by the programs. For the first time, federal legislation required that programs give the disadvantaged and minorities a role in the institutional decision making that affected them. The Metroplitan Development Act of 1965, which included the Model Cities Program, promoted regional comprehensive planning for community subsystems, including health, and encouraged the development and expansion of regional planning commissions and councils of governments.

In 1966, the Congress enacted the Comprehensive Health Planning and Public Health Services Amendment of 1966, P.L. 89-749. This legislation provided federal funding for two levels of comprehensive health planning, local and state. State and local comprehensive health planning (CHP) agencies soon came to be known respectively as 314(a) and 314(b) agencies after the sections of the federal act that outlined their structure and their functions.

The local or areawide 314(b) agencies that were created pursuant to P.L. 89-749, reflected a further evolution of health planning. They were similar to the less formal voluntary agencies that preceded them in that they defined their own geographic planning area and they lacked any formal method of forcing compliance with their plans depending instead on developing a consensus on the direction health care decisions

should take. They differed from their predecessor agencies in important ways also. The 314(b) agencies were required under the federal law to plan for health on a broader basis in the community, i.e., to include preventive health programs, health promotion activities, and environmental issues, etc., in their planning efforts. Another major change in the health planning process was the concept of consumer participation in planning. The 314(b) agencies were required to have a representative consumer majority on their boards of directors and thus effectuated a change from joint provider-business domination of the health planning process to consumer control. In Kansas, the 314(b) agencies were made responsible for deciding on the granting of certificates-of-need for the expansion, remodeling, or construction of health facilities under the original Kansas certificate-of-need statutes which preceded enactment of K.S.A. 65-4801 et seq.

The 1966 federal legislation also required the Governor of each state to designate a single state agency to conduct comprehensive health planning if the state wanted to receive federal public health service funds. In Kansas, the Department of Health and Environment was designated by the Governor as the 314(a) comprehensive health planning agency for the state. Governors were also required to appoint state health planning advisory councils that represented a majority of consumers. The original 1966 legislation gave little direction to the role of the state 314(a) agency in comprehensive health planning, thus the agencies in the various states tended to develop their roles on the basis of their own view of comprehensive planning.

Amendments to P.L. 89-749 required local government to be represented on the governing boards of areawide, 314(b) agencies and other federal acts assigned review and comment functions to the areawide health planning agencies, and to some extent to the state agencies.

Health planning changed again in 1974 with the passage of the National Health Planning and Resource Development Act of 1974, P.L. 93-641, which led to the creation of a nationwide system of local and state agencies that are charged with planning for all components of our health system. Kansas enacted our current health planning statutes, K.S.A. 65-4701 et seq., which reflect the planning structure set out in P.L. 93-641 in 1975. The Kansas certificate-of-need act then in existence was also repealed in 1975 and the current laws appearing as K.S.A. 65-48-4801 et seq., were also enacted in 1975.

P.L. 93-641 continued many of the concepts of health planning that had appeared in the 1966 Comprehensive Health Planning Act, i.e., both pieces of legislation attempted to develop new institutional structures to provide for community decisions about the health system, both mandated consumer participation and public involvement in health planning decisions, and both reflected the philosophy developed in the 1960s that health care is a right and that quality health care should be available to all persons and segments of society. P.L. 93-641 added on two new elements to the evolution of health planning; one, concern about the control of health care costs; and two, control of capital development as a mechanism for enforcing planning. P.L. 93-649 was enacted at a time when the health care system was entering into a period of rapid change in public priorities in health care, in the organizational structure through which health care is delivered and financed, and is now seen by many as unsuited to today's problems and priorities. This does not necessarily mean that health planning or the structure that has been created to carry it out will be discarded. Rather it may mean that the individual

states will set their own priorities and goals for health planning and will modify the planning structure both to better achieve their individual health priorities and goals and to reflect the unique characteristics of the states.

For an overview of the development of health planning see Appendix A.

Earlier this year, the House of Representatives considered three health planning bills. One (H.R. 6084), offered by Representative Henry Waxman, would have reauthorized the health planning program in much its current form. Another (H.R. 6173), offered by Representative Edward Madigan, proposed a modified health planning program based on the block grant concept. Representatives Richard Shelby and Phil Gramm offered a third bill (H.R. 4554) that would have repealed the health planning program. Although the Madigan bill was approved by the House Commerce Committee, Waxman, Madigan, and Shelby reached an agreement under which a compromise measure was substituted on the floor. The bill passed the House on a 302 to 14 vote. The House bill is now being held in abeyance until the Senate passes its own planning bill.

Last spring, Senator Lowell Weicker developed a proposal for a streamlined health planning program, with emphasis on CON functions. Since Senate Human Resources Committee Chairman Orrin Hatch would not schedule hearings on planning, Weicker tried to attach his measure in committee as a rider to a bill reauthorizing the National Institutes of Health (S. 2311). The Weicker proposal was defeated. Senators Hawkins and Quayle expressed limited support for temporarily continuing planning and joined forces with Hatch to develop their own health planning bill (S. 2720). Senator Weicker has been negotiating with the authors of S. 2720 for changes, but no agreement has been reached and it is not clear at this time whether S. 2720 will even be considered by the Senate.

A continuing resolution passed by Congress provides funding for health planning at current levels ($64 million) through December 17. When Congress returns from its recess November 29, it will have three weeks to pass another funding bill. Language in the current continuing resolution indicates that funding for planning probably will continue. Senator Harrison Schmitt, Chairman of the Senate Appropriations Labor-HHS Subcommittee, has been supportive of planning, and the conference committee report says that the "conferees have included bill language to continue the health planning program at the current operating level." It directs Health and Human Services (HHS) to see that "funds flow without interruption to health planning agencies so that they may continue to carry out their mission while the appropriate House and Senate committees continue their efforts to reauthorize the health planning program."

It appears that health planning will continue to be funded through continuing resolution — at least until the new 98th Congress takes office. Under the continuing resolution, planning remains in its present form and maintains its current functions and CON thresholds.

For a summary of H.R. 7040 and S. 2720 see Appendix B.

APPENDIX A

EVOLUTION OF COMMUNITY HEALTH PLANNING

| AGENCY TYPE | COMMUNITY HEALTH AND WELFARE COUNCIL | HOSPITAL REVIEW AND PLANNING COUNCIL | COMMUNITY FACILITIES PLANNING [s. 318] | AREAWIDE COMPREHENSIVE HEALTH PLANNING [s. 314(b)] | HEALTH SYSTEMS AGENCIES |
|---|---|---|---|---|---|
| Time Period | 1920s-1960s | 1950-1961 | 1961-1966 | 1966-1975 | 1975-present |
| Characteristic | | | | | |
| 1. Focus | Noninstitutional services | Facilities | Facilities | Health | Health |
| 2. Auspices | Private, nonprofit | Private, nonprofit | Private, nonprofit | Private, nonprofit* | Private, nonprofit* |
| 3. Governance | Consumer | Provider | Provider | Consumer | Consumer |
| 4. Authority | Persuasion | Economic pressure | Economic pressure | Persuasion | Legal Sanctions |
| 5. Financing | Private | Private | Private/ Federal | Increased Federal | Predominantly Federal |

*A small number (less than 12%) of those agencies were governmentally based.

INSTITUTE FOR HEALTH PLANNING
702 North Blackhawk Avenue, Madison, WI 53705

APPENDIX B

## HEALTH PLANNING DEREGULATION ACT OF 1982 (S.2720)
(Hatch/Hawkins/Quayle Bill)

### SUMMARY SECTION-BY-SECTION ANALYSIS

Sec. 2 - Purpose
Provides states with federal support to continue nonregulatory health planning activities at the state and local levels.

Sec. 3 - Authority
Repeals Title XV as in effect on September 30, 1982 and inserts new Title XV:

Sec. 1501 - Authorization of Appropriation
Authorizes $20 million for FY 1983.

Sec. 1502 - Allotments; Applications
Provides that state allotments be based on population, but with $100,000 minimum. Requires that states desiring to receive an allotment must submit an application to the Secretary.

Sec. 1503 - Payments to States
Directs the Secretary to make payments in accordance with the Intergovernmental Cooperation Act and directs that any funds not paid out to the states be returned to the Treasury.

Sec. 1504 - Use of Funds
Requires that funds shall be for state and local health planning and for experiments to demonstrate nonregulatory strategies to promote competition. Requires that states contribute 25 percent match for the federal 75 percent share and provides that funds will be available until September 30, 1984.

Sec. 1505 - Reports and Audits
Directs the states to prepare a report and audit of their activities.

Sec. 1506 - Definitions
Defines "state" to include the several states and the District of Columbia.

Defines "health planning" to include, at the state or local levels, by public or private entities, the development of a plan for the financing and delivery of health care and may include the compilation or conduct of studies, analyses and data collection. Excludes activities that regulate the planning, allocation, financing or delivery of health care resources or services, including CON and programs that regulate provider charges.

Sec. 4 - Effective Date: Repeal
Provides that new Title XV take effect October 1, 1982 and is repealed effective October 1, 1983.

# HEALTH PLANNING BLOCK GRANT ACT OF 1982 (H.R. 7040)
(Waxman/Madigan/Shelby/Dingell/Broyhill Compromise)

## SUMMARY SECTION-BY-SECTION ANALYSIS

Sec. 1 - Short Title
The "Health Planning Block Grant Act of 1982."

Sec. 2 - Repeal of Title XV
Provides that 30 days after the Secretary approves or disapproves a state application for funds under new Title XIX program, no funds are to be provided under Title XV to the SHPDA or HSAs.

Requires the Secretary to issue proposed new Title XIX regulations, allow 45 days public comment, and issue final regulations within 105 days of enactment. Requires states to apply for new Title XIX state grants within 90 days after regulations are effective. Requires the Secretary to approve/disapprove applications within another 30 days.

Requires states intending to apply for grants for regional health planning agencies, to do so within 150 days after regulations are effective:

(1) designate sub-state areas,
(2) designate regional health planning agencies (RHPAs), and
(3) submit grant applications to the Secretary

Requires the Secretary to approve/disapprove applications within another 30 days.

Allows the Secretary to grant Title XIX funds to SHPDAs and to HSAs during the transition period if the state is going to be applying for grants under the new program.

Sec. 3 - Revision of State CON Programs
Requires a state CON program to conform to new Title XIX requirements in order for the state to receive grant. Conformance deadline established per schedule of state legislature:

-- if in session upon enactment, and 3 months remain, 3 months from enactment;

-- otherwise, 3 months from beginning of next regular session

If a Governor certifies and the Secretary determines that legislature needs additional time, the Secretary may extend deadline up to 6 months.

Until the deadline, a state may use Title XIX grant funds for a non-conforming CON program.

A state may use Title XV funds during transition period for a CON program conforming to Title XIX.

Sec. 4 - Transition
Deletes state penalty clauses in Title XV and in P.L. 96-79. Adds "to the extent feasible" to the HSA staffing expertise requirement. Changes HSA staff minimum from 5 or one per 100,000 population to 3 or one per 300,000 population. Requires the Secretary to continue SHPDAs and HSAs in at least conditional status during the transition and not to enforce any Title XV requirements on them which are not also requirements under Title XIX. Requires transfer of funds and equipment remaining from SHPDA to new Title XIX state agency and from the old HSAs (through the state) to the new RHPAs.

Sec. 5 - Block Grants for Health Planning
Adds new Part D to Title XIX of PHS Act:

Subpart 1 - Grants to States

Sec. 1941 - Authorization of Appropriations
Authorizes $32 million for state allotments in FY 1983 and $33.6 million in FY 1984.

Sec. 1942 - Allotments
Provides that State allotments be based on population.

Sec. 1943 - Payments under Allotments
Provides for payments in accordance with the Intergovernmental Cooperation Act; sets forth related procedures including carry-over of funds; and provides that unobligated funds will be returned to the Treasury.

Sec. 1944 - Use of Allotments
Provides that funds will be used to: (1) operate a conforming CON program; and (2) develop a state health plan.

Sec. 1945 - Application; Report on Intended Expenditures
Provides a simplified application procedure and provision for state reporting of intended use of funds.

Sec. 1946 - Reports and Audits
Provides simplified reporting system of activities undertaken pursuant to Title XIX. Specifies that reports will be available to the public and provided to any interested person or public agency. Further, requires participating states to submit an audit report to their legislatures and the Secretary at least every two years.

Sec. 1947 - Nondiscrimination
Sets forth provisions regarding prohibitions against discrimination on the basis of age, handicap, sex, race, color, national origin or religion.

Subpart 2 - CON Program Requirements

Sec. 1951 - Program Requirements
Requires review and determination of need for (1) major medical equipment and institutional health services, and (2) capital expenditures.

Provides that under certain conditions a state may not require a CON for the offering of an inpatient institutional health service, the acquisition of major medical equipment, or the obligation of a capital expenditure for the provision of an inpatient institutional health service by: (1) an HMO or combination of HMOs; (2) a health care facility which primarily provides inpatient services and is controlled directly or indirectly by an HMO; or (3) a health care facility or portion thereof which an HMO or combination of HMO's has leased. Also includes related provisions regarding special review of other HMO projects. (Note: these HMO provisions are essentially the same as the Title XV provisions.)

Provides that a CON is not required for the acquisition of major medical equipment which will not be owned or located in a health care facility (e.g., a physician's office) unless that equipment will be used to provide services for inpatients of a hospital. However, notice of intent to purchase is required. Donations and leases are to be considered acquisitions.

Requires that state agency set a maximum time period for project completion and provide for periodic review of progress. Requires that state agency specify maximum amount that may be obligated and provide for subsequent review if this amount is expected to be exceeded. Also provides that states may withdraw CON for lack of a timely, good faith effort. Requires that state agency incorporate criteria and procedures outlined in the bill. (Note: essentially the same as Title XV provisions.)

Sec. 1952 - Criteria for Review
Requires state agency to base CON decisions on the application's consistency with state health plans.

Requires that CON issuances not be subject to criteria or conditions not related to state health plans or not under control of applicants.

Requires that state agency provide, in writing, reasons for disapproving applications.

Requires state agency to issue regulations establishing requirements for a complete application; to perform completeness review and make determination within 20 business days of receipt; and to make no more than one request for additional information.

Provides that if a state agency does not act within 110 business days of the date application is determined to be or is deemed complete the CON application is deemed approved.

Sec. 1953 - Procedural Requirements
Requires a hearing, upon request of any affected person, including an RHPA, before a CON decision. Provides that the state's administrative procedure law will apply to proceedings on an application for a CON. Where not provided by such law, this section sets forth requirements for administrative hearings and review; and for judicial review of administrative decisions. Requires state agency to provide copy of any CON application to appropriate RHPA, upon request.

Sec. 1954 - State Health Plan
Requires that the plan be issued by the state's chief executive officer and that it include a description of institutional health services needed within the state and how such services should be distributed. Plan is to be based on recent data, relating, to the extent feasible, to the preceding 2-year period.

Requires that the states consider: the needs of health professional training programs; and the availability of and need for facilities for osteopathic and allopathic physicians and patients, and for training programs for such physicians.

Requires that the state agency hold a public hearing, including opportunity for cross-examination of principal officials (other than CEO), prior to issuance of a state health plan.

Sec. 1955 - Definitions
Defines "institutional health service" to mean a health service provided by a health care facility which entails annual operating costs in excess of $1,000,000. States can reduce this threshold to $500,000.

Defines the term "health care facility" to include hospitals, nursing homes, and any other facility included by the Secretary in the definition by regulation. However, the regulations may not include a physician's office which is not within a health care facility.

Defines "capital expenditure" to mean an expenditure made by a health care facility, which is not chargeable as an operating expense: which results in patient care costs, and which exceeds $5,000,000. States can reduce this threshold to $1,000,000.

Defines "major medical equipment" to mean equipment which is used for the provision of medical and other health services and which costs in excess of $5,000,000. States can reduce this threshold to $1,000,000. This definition does not include equipment of a free-standing clinical laboratory (as defined in this section).

Note: to reduce the thresholds states must certify to the Secretary that they have personnel and financial resources to effectively administer such a program.

Defines "health maintenance organizations" to include those qualified under section 1310(d) and those presently defined in this section 1955 (identical to Title XV definition).

Subpart 3 - Grants for RHPAs

Sec. 1961 - Grants
Sets forth application and approval procedures for grants to states for regional health planning agencies (RHPAs). RHPAs apply to states and states apply to the Secretary.

Provides for grants on a population-based formula. Maximum is the lesser of 50¢ per capita or $3 million. Requires local match after FY 1983 of 15 percent of the FY 1983 budget.

uthorizes an appropriation of $32 million for FY 1983 and $33.6 million for FY 1984.

Sec. 1962 - Designation of Health Planning Areas
Provides for designation and redesignation of health planning areas by the state CEO. Interstate areas are allowed. Not all parts of a state need be designated. Criteria are the existing ones of 500,000 to 3 million population, not splitting an SMSA, and inclusion of a tertiary care center, but a CEO may ignore any or all of the criteria upon determination that an area would be "more appropriate for effective health planning."

Sec. 1963 - Designation and Organization of RHPAs
Provides that RHPAs will be designated by the CEO and may be a nonprofit private agency, or a unit of general local government, or a public regional planning body. In the case of a nonprofit private agency, the majority (up to 60%) of the governing body must not be providers as defined by this section, and must be residents of the area. "Providers" is defined essentially as Title XV, except that a local elected official is not to be considered a provider.

Provides that RHPAs may not accept contributions from certain entities. Excludes from the prohibition (1) health care insurers (2) a contribution from a health care facility not in a SMSA if contribution is less than half the required local match.

Sec. 1964 - Functions of RHPAs
ovides that the functions of an RHPA shall be to:

(1) assist the state agency in the development of the state health plan, including the submission of a description of institutional health services needed in its area and how such services should be distributed;

(2) encourage individuals in its area to carry out parts of state health plan applicable to the area; and

(3) carry out a program of public information regarding pertinent provisions of state health plan relating to the area.

Prohibits the granting of funds for RHPAs if those agencies are to conduct CON hearings or approve/disapprove CON applications, or if applicants are required to have a review or recommendation by the RHPA.

Provides for protection against liability of the RHPA, its governing body members and agency employees.

Sec. 5 - Technical Assistance Center for Health Planning
Requires the Secretary, by grant or contract, to assist a center for multi-disciplinary health planning methods development and technical assistance to state agencies and RHPAs. Continues the requirements of Title XV for center to be public or private non-profit, and the requirements for the director and staff. Permits the Secretary to use up to $1.5 million from funds appropriat-
under sections 1941 and 1961.

MEMORANDUM

November 4, 1982

TO: Special Committee on Public Health and Welfare

FROM: Kansas Legislative Research Department

RE: Options in Health Planning

It appears that federal support for state and local health planning will diminish over the next several years, if not be withdrawn totally. Although it does not appear that major changes in the National Health Planning and Resource Development Act of 1974 will be made in the remainder of 1982, it is likely that many of the current federal requirements and restrictions on health planning will be repealed by the 98th Congress. Although many states have adopted a "wait and see" attitude in regard to health planning and facility regulation pending Congressional action, others such as Florida and Maryland, have revised their comprehensive health planning systems to restructure and redirect health planning to fit their own states, and others, such as Tennessee and South Carolina, have appointed task forces to evaluate and make recommendations about the future role of health planning in their respective states. Regardless of the method, the probability of more state control over health planning with less federal intervention gives Kansas an opportunity to look at restructuring, streamlining and integrating the state's health planning system into a health planning system that is tailored to the state's health goals, governmental structure and needs.

There are a number of specific factors that could be included in designing a health planning system for Kansas, among which are: the state's goals or priorities in health; the location of responsibility for health planning within state government; the role of local involvement in state health planning; the role of the state health plan in budget, block grant and health policy decisions; the use of health data collected in the planning process by other agencies of government; the coordination of health planning with other state programs such as Medicaid and aging programs; the role of health planners in evaluating health policy options and alternatives for the executive and legislative branches of government; the relationship of health planning to regulatory functions such as certificate-of-need programs; and funding sources for health planning.

State Goals and Priorities

The present health planning system was expected by those who designed it to accomplish numerous and far-reaching goals. Some persons believe that the health planning goals set out in P.L. 93-641 are unrealistic in scope and fragment and diffuse health planning efforts to the point that they are less effective than they might be if planning priorities were set by the states and followed by planners.

For most states, the goal of cost containment is a top priority and one that has received increased emphasis in the planning process even though the existing health planning system is not structured to address all the factors that contribute to rising health costs. Most important of the cost rise contributors which lie outside the planning system are the present reimbursement patterns. Also outside the system are

Att. II

federal manpower training grants, research funding, and various construction loan programs. The cost results of incomplete or delayed federal payments for health services also are outside the purview of the current health planning system.

Other major health problems that persist in Kansas are chronic disease, maldistribution of health resources, a continuum of care for the elderly, and lack of competition strategies in the health care delivery system. Other health policy priorities identified by some 13 states surveyed by the Alpha Center include Medicaid cost control; mental health, mental retardation and developmental disabilities services and deinstitutionalization; public health program funding; environmental concerns; health promotion and disease prevention; and data collection and analysis.

## Options

Which of the above should constitute priority goals for health planning in Kansas if the state were free to set its own planning goals and priorities? What other goals should be emphasized in health planning? Should there be a mechanism built into state law to provide for a periodic reassessment of the state's health planning priorities?

## Location of Responsibility For Health Planning

There is considerable variation in the placement and structure of current State Health Planning and Development Agencies (SHPDAs). For a program that imposed one model of health planning on widely varying state and local conditions, states have devised an interesting array of structural arrangements for their planning and certificate of need (CON) functions. The current location of the SHPDA ranges from the health department to commissions reporting to the Governor. As shown in Table 1 below, 84 percent of the SHPDAs are located in a state health department or in a multi-function department which includes health.

TABLE I

PRESENT LOCATION OF SHPDAs*

| | Number | Percent |
|---|---|---|
| 1. Health Department | 23 | 45% |
| 2. Multi-Function Department Which Includes Health (e.g., Human Resources; Health and Human Services) | 20 | 39 |
| 3. Administrative Department (e.g., Management and Budget; Planning) | 2 | 4 |
| 4. Commission (e.g., Usually reports to or is appointed by the Governor) | 6 | 12 |
| TOTAL | 51 | 100% |

* Source: Data collected by the Alpha Center.

Florida and Maryland both restructured their health planning systems during their 1982 legislative sessions. Maryland's new law establishes an independent Health Resources and Planning Commission located, for administrative and budgetary purposes, in the Department of Health and Mental Hygiene. The commission, which replaces the SHPDA and SHCC, will house both the health planning and regulatory programs. A major reason for creating the commission was to elevate planning and CON to make them co-equals with Maryland's Health Services Cost Review Commission.

Under Florida's new law, the Department of Health and Rehabilitative Services will continue to administer planning and CON, with the planning function falling within the jurisdiction of the Office of Planning and Development, and CON operated through the Department's Office of Community Medical Facilities.

Preliminary recommendations contained in the first draft of a discussion paper prepared by a Tennessee Task Force on the future of health planning call for the abolishment of the Tennessee Health Planning and Resources Development Authority, which currently administers the health planning program, with responsibility for health planning shifted to the Office of State Planning. In addition, the staffs of the Planning Authority and the Health Facilities Commission, which currently contracts with the Authority to do CON reviews, would be merged and placed as a division in the Office of State Planning. In accordance with these preliminary findings, the Health Facilities Commission would be maintained as an independent board for final decision making on CON.

It is clear there is no one location within state government viewed as the most desirable placement for health planning. Indeed, the location and type of agency that is assigned responsibility for health planning may be decided on the basis of the individual state governmental structure, policies, and other decisions about the role of health planning as a health policy guide, budget tool, data collector, or coordinating mechanism for all state health functions. The following questions might be considered in discussion of recommendations for the location of health planning within state government:

1. What should be the role of health planning in the development of state health policy? Block grant allocations? Coordination of state health functions?

2. Should health planning and certificate-of-need and other regulatory functions be separated? Within one umbrella agency? Within different agencies?

3. Should health planning and health data collection and evaluation functions be separated? Within an umbrella agency? Within different agencies? Within a separate health planning and health data agency?

4. Should the responsibility for health planning be located within an umbrella agency? A separate commission or board?

5. Should a statutory system be devised to provide input from other agencies into the development of health plans and vice versa? Through the SHCC if it is retained? Through an advisory council? What agencies should be included? Should representatives of the Governor's Office and the Legislature be included?

Local Involvement in State Health Planning

If it is assumed that the structure of health planning will be determined by the state in the future, it may also be assumed that there will be changes in the way local input is built into the state health planning process. Indeed, changes have already taken place with the demise of two of the health systems agencies that once functioned in Kansas and the prospect of reduced or no federal funding for the two remaining health systems agencies. In considering the role of local health planning in the future, some consideration should be given to what has been learned from almost two decades of organized local health planning, i.e., what have been the strengths and weaknesses of local health planning and what has local input contributed to the development of health policy and health planning.

The following questions could be considered in determining how local input will be obtained:

1. What is the function(s) of local input?
   a. To assist in regulatory decision making?
   b. To identify problems?
   c. To develop specific local plans?
   d. To implement statewide priorities in local areas?

2. When and how often is local (public) input desired?
   a. Only as reaction to state policy and planning decisions?
   b. As citizen participation in the process?

3. How will accountability for input be insured?

4. What resources are needed and available to encourage or sustain local input?
   a. How much volunteer effort is expected?
   b. How much staff support is needed to sustain the volunteer effort?

5. What kind of structure(s) is available for soliciting local input across the state and is it likely to survive?
   a. What is the political feasibility of using existing structures?
   b. How easy would it be to convert, modify or redesign existing structures to meet the state needs for local input?
   c. Are other organizations available to perform the function?

Following are some options for securing public input in the health planning process. The options range from minimum to maximum local input and each option includes pros and cons.

1. Public Hearings and Use of the Media

Public hearings are the minimal form of local input that should be available. The more extensive the use of the media to highlight the public hearing process, the greater the public response.

Pros

a. If well organized in advance, can reach a reasonably wide range of individuals and organizations.

b. Is inexpensive and demands a short period of intensive state staff involvement.

c. Can provide some degree of meaningful reaction to state planning and policy documents.

Cons

a. Does not provide a forum for sustained local input.

b. Is essentially a reactive process and does not allow for local participation in the plan development process.

c. May be dominated by highly organized and vocal local organizations so that local representation is questionable.

d. Often fails to attract reaction of other than the personally involved or the professional reactors.

2. State Agency Appointed Technical Advisory Committee or State Level Interagency Planning Task Force

Some local input, essentially for planning purposes, can be obtained through the use of technical advisory committees or state level interagency planning task forces.

Pros

a. Allows the state to select the best talent or expertise in any given health field.

b. Increases probability of acceptance of the plan from professional groups or other state agencies that may be important for implementation.

Cons

a. Would leave some major consumer and provider groups out of the process.

b. The more diverse the group, the greater the time period required to develop a plan or other final project.

c. Is only useful for specific component planning.

3. A Designated Panel of Agencies Reacting by Mail

This option would involve identification of interested parties, both at the state and local levels, who might be willing to respond in writing to state requests for health planning input.

Pros

a. If state level agencies are used, they can solicit input from their local units.

b. A wide array of community health interest can be solicited.

c. Costs for mailing documents or other materials are minimal.

Cons

a. Essentially, this is a reactive process.

b. Local input and accountability is not assured.

c. Planning would be fragmented, rather than comprehensive, since groups have a tendency to respond primarily in terms of their own interest.

4. Business Coalitions or Other Successor Organizations

Pros

a. Coalitions are usually composed of influential individuals in business, insurance companies, government and/or medical societies.

b. Are local in nature and seek to develop goals and objectives which respond to the local environment.

c. Are often self-supported through membership fees or contributions.

Cons

a. Do not have comprehensive health planning as their major focus and almost always have cost containment as their major priority. Little reason to expect a balanced approach at least for a few years.

b. Lack of uniform geographic coverage and membership.

c. May only emerge in large population centers.

d. Unlikely that they will represent broad consumer and provider interests.

5. Use of the SHCC or a Successor State Health Council

Pros

a. Basic structure of the SHCC is already in place, including committees.

b. Provides structure for obtaining technical expertise and input on specific health topics.

c. A mechanism/process could be developed for continued broad consumer and local input.

Cons

a. Lack of direct accountability to any constituency.

b. Unless a broad based membership is specified, could lack adequate representation.

c. Some expenses involved in transporting consumer members and the logistics of coordinating statewide meetings.

6. A Single Designated Local Agency

In some states, a general purpose regional organization could be designed to provide local input on health planning issues. Such groups include A-95 bodies or regional planning commissions, etc.

Pros

a. Already have an organizational structure that may be expanded or modified to include health planning issues.

b. Allows for more structured monitoring of activities and local accountability.

Cons

a. State may have to offer incentives in the form of state assistance, funding for additional expenses, or both.

b. Health planning skills and expertise may be lacking.

c. Health planning may be a low priority when pitted against other program demands on local agencies.

7. Continuing HSAs with Little or No Staff

Some HSAs may decide to continue operation, but with little or no staff and without official HSA status.

Pros

a. May still have a core of experienced providers and consumers who are well suited to providing input.

b. Leaves in place a local health planning structure.

c. Requires very limited financial resources and would impose no new responsibilities.

Cons

a. Without mandate or official HSA status, consumer and particularly provider participation could diminish substantially.

b. Without adequate staff support, this local volunteer network is likely to dissipate and become ineffective.

c. Lessened volunteer participation and community interest could leave the HSA nonrepresentative.

9. State Supported Local Health Agencies

A number of states have passed legislation which would continue some funding for local health planning agencies and made provisions for specific functions to be continued.

Pros

a. Duties of local health planning agencies can be more clearly defined and circumscribed.

b. Maintains existing network for local input, although perhaps with reduced staffing.

c. Leaves in place a local health planning structure which can allow for a smoother transition to the next phase of health planning.

Cons

Requires state and/or other financial support.

Linking State Health Planning, Health Policy, Budgets, Data Collection and Evaluation

Currently, the health planning system operates substantially in accordance with the provisions of the Health Planning and Resource Development Act of 1974. That is, plans are developed by health systems agencies and used as the basis for the preparation of state health plans which reflect statewide needs. The implementation of the health planning depends on four broad types of tools — involvement of public and private organizations and agencies, certificate-of-need reviews of institutional health services, review of the continuing appropriateness of institutional services, and review of proposed use of federal funds. There are, however, no formal mechanisms built into the Kansas health planning laws to provide that the end product of health planning is utilized or at least considered in the development of state health policy by the state health agency, the Governor, or the Legislature. Nor is there a formal recognition of the health priorities that are identified in the health planning process by which funding decisions are made by other state agencies, the Governor, and the Legislature. Two other by-products of health planning, health data collection and evaluation, and the expertise developed by health planners in the area of data collection and evaluation are not utilized by other agencies of the state. The following questions could be included in discussions of the future role of health planning.

1. Should the health needs assessment and health priorities identification function of health planning be utilized by other agencies as a guide to decision making? By the Budget Division and Governor? By the Legislature?

2. Should health planners review and evaluate health policy options for other state agencies, i.e., proposed changes in the Medicaid Program?

3. Should decisions about the allocation of federal block grants for health be based on needs assessments and priorities developed through the health planning process?

4. Should the evaluation of health policies as set out in state laws and appropriations be a function of state health planning?

5. To what degree should health planning be integrated with other state functions? Formally or informally?

6. Should the health planning program develop new health related data as needed by other components of state government?

7. Should the health planning program be assigned the responsibility for special studies such as health technology assessment, evaluation of changes in the financing of health care, etc.?

8. Should the health planning program provide technical assistance to legislative committees, advisory groups, providers?

Funding of State Health Planning

In view of the probability of reduced or zero federal financial support for health planning, the issue of funding needs to be addressed in discussion of the future of health planning. The following listing represents some options for funding.

1. Certificate-of-need application fees
2. License and certificate-of-need fees
   a. Facility
   b. Manpower
3. User fees
4. Reimbursement tax, i.e., a tax on provider revenues
5. State general fund revenues
6. Allocation of part of the health insurance premiums tax
7. Foundation or other private funding sources
8. Fees for services such as data collection and analysis
9. Combinations of funding sources

MEMORANDUM

January 24, 1983

TO: House Committee on Governmental Organization

FROM: Kansas Legislative Research Department

RE: Board of Healing Arts

## Definition of Terms

K.S.A. 65-5001:

(b) "Registration" means the process by which the state identifies and lists on an official roster those persons who meet predetermined qualifications and who will be the only persons permitted to use a designated title.

(c) "Licensure" means a method of regulation by which the state grants permission to persons who meet predetermined qualifications to engage in an occupation or profession, and that to engage in such occupation or profession without a license is unlawful.

## Composition and Duties of the Board

The Board of Healing Arts was established in 1957 so that "the public shall be properly protected against unprofessional, improper, unauthorized, and unqualified practice of the healing arts and from unprofessional conduct by persons licensed to practice underthis act" (K.S.A. 65-2801). The Board consists of the following 13 members who are appointed by the Governor, with the consent of the Senate, to four-year staggered terms:

1. five members who hold a degree of doctor of medicine;
2. three members who hold a degree of doctor of osteopathic medicine and surgery;
3. three members who hold a degree of doctor of chiropractic;
4. one member who holds a degree of podiatry; and
5. one public member.

Except for the public member, all members must have been actively engaged in Kansas in their respective fields at least six consecutive years immediately preceding their appointment.

Att. III

In making the appointments, the Governor is required to take into consideration the names of persons who are on lists submitted by the professional societies or associations represented on the Board, except in the case of the podiatrist and public members.

The Board of Healing Arts is charged with administering the provisions of the Kansas Healing Arts Act (K.S.A. 65-2801, et seq.). The Act provides for the licensure and regulation of medical, osteopathic, and chiropractic doctors, and the registration of physician's assistants. In addition, the Board is responsible for administering other statutes which bring within its jurisdiction the registration and certification of physical therapists and physical therapy assistants (K.S.A. 65-2901 et seq.) and the licensing and regulation of podiatrists (K.S.A. 65-2001 et seq.).

In performing these latter duties (administering the Physical Therapy Act and the Podiatry Act), the Board works with two committees which assist it in matters relating to their respective professional fields.

The first is the State Examining Committee for Physical Therapy, a statutory five-member committee directed to "assist the board (of Healing Arts) in carrying out the provisions of this law, regarding the qualifications and examinations of physical therapists and physical therapy assistants." The members, who are appointed to four-year terms, consist of three physical therapists appointed by the Governor, a physician licensed by the Board of Healing Arts to practice medicine and surgery appointed by the Board, and the Secretary of the Board of Healing Arts. The Committee, under the administration of the Board of Healing Arts, registers, examines, and regulates physical therapists in Kansas. (This Committee was under the provisions of the Sunset Law, but those provisions were removed by the 1981 Legislature.)

The second committee is the Advisory Committee on Podiatry, a three-member committee established in 1975. The Committee consists of three podiatrists who advise and consult with the Board of Healing Arts in the administration of laws regarding the qualifications and examination of podiatrists.

The professions under the jurisdiction of the Board of Healing Arts are shown in Table I.

Table I
Professions Under the Jurisdiction of the
Board of Healing Arts

| Profession | Type of Jurisdiction | Relevant Statutes | Number Licensed Registered 10-31-82 |
|---|---|---|---|
| Medical doctors | Licensure | Healing Arts Act (K.S.A. 65-2801 et seq.) | 6,329 |
| Doctors of osteopathic medicine | Licensure | Healing Arts Act (K.S.A. 65-2801 et seq.) | 410 |
| Chiropractors | Licensure | Healing Arts Act (K.S.A. 65-2801 et seq.) | 741 |
| Physician's assistants | Registration | Healing Arts Act (K.S.A. 65-2801 et seq. | 60 |
| Physical therapists* | Registration | Physical Therapy Act (K.S.A. 65-2901 et seq.) | 495 |
| Physical therapy assistants* | Certification[a] | Physical Therapy Act (K.S.A. 65-2901 et seq.) | 105 |
| Podiatrists** | Licensure | Podiatry Act (K.S.A. 65-2001, et seq.) | 101 |

*Assisted by the State Examining Committee for Physical Therapy
**Assisted by the Advisory Committee on Podistry

[a]In this context, certification is the same as registration.

The duties of the Board include determining the qualifcations of persons who wish to practice in Kansas in the professional areas under the Board's jurisdiction, administering various examinations, issuing licenses or permits to practice, and investigating and hearing complaints concerning practitioners under the Board's jurisdiction. The qualifications of practitioners are set forth in Kansas statutes and the rules and regulations of the Board.

The Board administers examinations twice a year in each professional area under its jurisdiction, except for physician's assistants. Examinations for physician's assistants are given at Wichita State University. All of the examinations are standardized tests administered by the Board (or by Wichita State University, in the case of physician's assistants), except for the podiatry examination. That test is developed by the Board itself with the assistance of the Advisory Committee on Podiatry.

All persons who are licensed, registered, or certified by the Board must renew their permits to practice annually. All practitioners except physical therapy assistants are required to show proof of having met continuing education requirements before their permits may be renewed.

The Board receives approximately 100 complaints against licensees annually. The Board contracts with an investigator who gathers information on serious complaints and, if warranted, the Board holds disciplinary hearings which can result in a license or permit to practice being revoked, suspended, or limited. The Board usually holds five or six hearings a year although there has been an increase in both the number and length of hearings during the last several years. The Board contracts with an attorney for its legal services.

Fees which may be collected by the Board are listed in the statutes pertaining to each of the professions under the Board's jurisdiction. Except in the case of physical therapists and physical therapy assistants, the statutes also set a limit on each fee. For physical therapists and physical therapy assistants, the limits are set in rules and regulations of the Board. Table II shows some of the fees collected by the Board.

Table II
Selected Fees Collected by the
Board of Healing Arts

| Profession | Type of Fee | Current Amount |
|---|---|---|
| Medical doctors | Examination | $160 |
| | Initial Licensure | 130 |
| | Renewal | 50 |
| Doctors of osteopathic medicine | Examination | 160 |
| | Initial Licensure | 130 |
| | Renewal | 50 |
| Chiropractors | Examination | 40 |
| | Initial Licensure | 130 |
| | Renewal | 50 |
| Physician's assistants | Examination | --- |
| | Initial Registration | 50 |
| | Renewal | 10 |
| Physical therapists | Examination | 85 |
| | Initial Registration | |
| | Renewal | 15 |
| Physical therapy assistants | Examination | 85 |
| | Initial Certification | |
| | Renewal | 15 |
| Podiatrists | Examination | 30 |
| | Initial Licensure | 130 |
| | Renewal | 50 |

## Board Operations and Budget

The Board is funded entirely from fees it collects for issuing licenses and permits, giving examinations, and performing other duties for which a charge is assessed. Twenty percent of its income is credited to the State General Fund. The remainder is credited to the Healing Arts Fee Fund which supports the operation of the Board office at 503 Kansas Avenue. The Board's staff consists of six persons: an Executive Secretary and a five-person clerical staff. Each year the Board selects one of its members to serve as Secretary and that person also receives a salary fixed by the Board. In addition, the Board contracts with an attorney and an investigator.

For the current fiscal year (1983), the Governor recommends an expenditure limitation of $285,153. Major items in the Budget are salaries ($132,284), travel and subsistence for Board members and staff ($23,500), and contracts with the attorney and investigator ($62,000).

For FY 1984, the Governor recommends an expenditure limitation of $313,683. The greatest growth in the budget for FY 1984 over the current year is in the area of contracts for legal and investigative services for which the Governor recommends an expenditure of $81,800. The Board requested that level of funding because of a greater than usual amount of legal activities in recent years. If the Governor's recommendations for the Board's budget are approved by the Legislature, there will be a balance in the Healing Arts Fee Fund of $377,925 at the end of FY 1984.

CR/pa

ATTACHMENT IV

January 25, 1983

Good Morning, Mr. Chairman and members of the Government's Organizations Committee. My name is Guillermo Barreto-Vega, Executive Director of the Health Systems Agency of Northeast Kansas (HSANEK). The HSANEK is a non-profit organization which has a 50 member Board of Directors, of those 25 are appointed by County Commissioners and 25 selected to represent the socio-economic characteristics of Northeast Kansas residents.

I appreciate this opportunity to present the following testimony on H.B. 2013, an Act concerning the expiration of the Kansas Health Planning and Development Program. Our testimony is a statement of support for H.B. 2013 for the following reasons:

First, during the 97th Congress, the U.S. House of Representatives passed H.R. 7040, Health Planning Block Grant Act of 1982, with a vote of 302 in favor and 14 against. The net effect of this bill was to extend the health planning federal legislation for two more years and to increase the CON thresholds on Capital Expenditures to $5,000,000, on Major Medical Equipment to $1,000,000, and Health Facility Service to $1,000,000. Further, this Bill would have transferred the Health Planning Program to the states through Block Grants. Each state would have had the perogative to request Federal funds to conduct state and local health planning programs. In addition, each state would have taylored and administered the health planning program to meet its individual needs.

On the other hand, the U.S. Senate introduced S-2720 the Deregulation Health Planning Act of 1982. However, a last minute hold on the Bill by the late HHS Secretary stopped the compromise amendment to the Bill from passing.

Atch. IV

Second, the Congress has insured through Continuing Resolution, the federal funding of the Health Planning Program for FY 83.

All these actions by the U.S. Congress indicate positive support for the Health Planning Program at the National level.

Finally, the Kansas Special Committee on Public Health and Welfare considered and studied the Kansas Health Planning Program during the summer of 1982. One of the recommendations of that Committee is H.B. 2013, which is to extend the Kansas Health Planning and Development Act for one more year, until July 1, 1984. This extension will enable a proposed Kansas Health Planning Commission to study the program and submit recommendations to the governor and the legislature by January, 1984.

For the above reasons, the HSANEK supports the passge of H.B. 2013.

# Health Systems Agency of Southeast Kansas, Inc.

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Diversity of knowledge is the fundamental foundation upon which the seeds of democracy were implanted, and where our country's heritage subsequently flourished. Two years ago HSASEK adopted a new "Systematic Planning" method which facilitated the Agency in the acquisition and dissemination of medical care information to the average citizen. Community needs emerged over institutional needs as health planning made positive and effective changes in the allocation of resources as it related to mortality and morbidity. At last, local citizens began to realize the importance of prevention, causes, and costs of medical services. Subsequently, with the expertise of our Board and its Committees, cooperation between providers and consumers was evidenced.

With the birth of community interest came severe federal funding cuts and the threat of complete elimination of local community planning. Staff layoffs occurred and the most immediate problem became the preservation of some form of local planning. Efforts were directed toward the establishment of a consumer group, and toward an employer coalition. The Consumer Coalition for Health was established and become incorporated. In a joint effort, HSASEK and the Consumer Coalition published the first "Consumer Guide to Health Care in Sedgwick County," and if feasible, will pull resources to publish another manual.

HSASEK has continued its efforts to maintain local planning by pleading its case with all national representatives from Kansas. Although competition within the medical care system has been advocated by the current administration, no proposals have reached Congress for debate. Also, serious concerns must be thoroughly addressed before competition is embraced as the solution to the current cost problem (i.e., licensing of professionals, corporate maximization of profits, elimination of third party reimbursement, etc.). Consequently, a hybrid form of competition will emerge.

Local health planning will be needed to help implement whatever competitive model is adopted. Only local planning can monitor the changing system so as to insure continued success. Systems planning suggests that we first move into model projects and the best of those results combined before national canges are initiated. Unfortunately, there are no simple solutions to such complex issues.

One such issue is that of Certificate of Need (CON). Although CON is only one very small part of Health Planning, it has somehow, unfortunately, been equated as Local Health Planning. Even at the national level, some proponents of competition point out that CON is anti-competitive and therefore we do not need Local Health Planning. Health Systems Agencies have directives that are to some degree contradictory, i.e. (1) increase accessibility and reduce costs, (2) avoid duplication of services and promote competition.



Atch. V

Providers can easily convince consumers that new technologies and new services are needed by the community. Local hospitals often combine the political clout of the American Medical Society and the American Hospital Association to pursuade local, state, and national policies. Better health has somehow been equated with more of everything (i.e., more technology, more facilities, more services). A major problem is that institutional needs do not alway translate directly to community needs.

Local Health Planning is a form of particiaptory democracy on which our government was founded. One of the most important principals of self-government is that information is power. Without Local Health Planning, the tax payors are stripped of unbiased information.

What has Local Health Planning done other than Certificate of Need?

- Played a role in working with local providers and consumers in developing additional necessary health services, including obtaining needed professionals in underserved areas.

- Stimulated and upgraded planning efforts by institutions and agencies.

- Helped develop a pool of community leaders, interested in and knowledgeable about health issues.

- Broadened the base of volunteer participants needed for reaching a consensus in communities.

- Provided an open, participatory forum for the public discussion of issues related to the provision of health care services within local communities.

Individual states have approached the issue of "cost" in various ways. Maryland's legislation continued state and local planning, even if federal funding should be withdrawn, but removed local agencies from mandated CON review; emphasized health policy formation, state health plan development, and CON review at the state level; and simplified the CON review process.

If Kansas is to become a leader in Local Health Planning and to promote competitive markets, three steps are seen as important:

1. Establish a task force of senior officials to explore the implications of promoting competition.

2. Develop the approaches and criteria to be used in assessing competition in specific markets.

3. Educate staff and volunteers as to means, goals and criteria to be used.

Let us all work together at the local, state and national levels to help promote Local Health Planning.

RH:mgf
1/24/83
SPEECH-2-H

ATTACHMENT VI

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON HOUSE BILL NO. 2013

PRESENTED ON JANUARY 25, 1983

HOUSE GOVERNMENTAL ORGANIZATION COMMITTEE

This is the official position taken by the Kansas Department of Health and Environment on House Bill No. 2013.

NEED FOR:

House Bill No. 2013 extends the expiration date for the Kansas Health Planning and Development Act (K.S.A. 65-4701, et seq.) to July 1, 1984. This act, and the program in Kansas, respond to federal legislation. The National Health Planning and Resources Development Act (P.L. 93-641) was enacted in 1975 and provided funds to state and local planning bodies to accomplish four goals through planning and development:

- improve health;
- improve access to needed health care services;
- restrain unnecessary increases in health care costs; and
- prevent duplication of expensive health care resources.

Further, the national law provided the opportunity for states to develop a State Health Planning Program and Certificate of Need Program to review new institutional health services. If a state did not develop these programs the state would lose all federal public health funds, mental health funds, and alcohol program funds (approximately $15 million). This is the same basic approach as that used in the highway program; either establish a 55 mile per hour speed limit, or lose the federal highway dollars.

Kansas decided to comply and has used the federal program dollars to focus research and planning activities on Kansas priorities, as well as meeting the federal requirements.

Atch. VI

During last year's legislative session, it was expected that the Reagan Administration would succeed in dismanteling the Health Planning and Certificate of Need Programs and, therefore, Kansas lawmakers decided to "sunset" the Kansas programs if they were phased-out federally. However, Congress has acted to extend, through a continuing resolution, the programs through Federal Fiscal Year 1983. Further, it is expected that during 1983, Congress will decide on the future of the National Health Planning Program by either designing a new program, or phasing-out the existing program. It appears now that a new program will be legislated that may be funded as a block grant to states, which should allow more flexibility for state program design and functions.

DEPARTMENT'S POSITION:

The Department of Health and Environment recommends that House Bill No. 2013 be passed.

Presented by: Barbara J. Sabol, Secretary
Kansas Department of Health and Environment