11-1972

0187 Committee on Hospitals, Part II

Colorado Legislative Council

0187 Committee on Hospitals, Part II

Report to the Colorado General Assembly:

COMMITTEE ON HOSPITALS

Part II

COLORADO LEGISLATIVE COUNCIL

RESEARCH PUBLICATION NO. 187

November, 1972

LEGISLATIVE COUNCIL

OF THE

COLORADO GENERAL ASSEMBLY

Representatives	Senators
C. P. (Doc) Lamb Chairman	Fay DeBerard, Vice Chairman
Ralph Cole	Fred Anderson
Phillip Massari	Joe Calabrese
Harold McCormick	George Jackson
Hiram McNeil	Vincent Massari
Clarence Quinlan	Ruth Stockton
John Fuhr, Speaker of the House	William Armstrong, Senator Majority Leader

* * * * * * * * * * *

The Legislative Council, which is composed of six Senators, six Representatives, plus the Speaker of the House and the Majority Leader of the Senate, serves as a continuing research agency for the legislature through the maintenance of a trained staff. Between sessions, research activities are concentrated on the study of relatively broad problems formally proposed by legislators, and the publication and distribution of factual reports to aid in their solution.

During the sessions, the emphasis is on supplying legislators, on individual request, with personal memoranda, providing them with information needed to handle their own legislative problems. Reports and memoranda both give pertinent data in the form of facts, figures, arguments, and alternatives.

COMMITTEE ON HOSPITALS

PART II

Legislative Council

Report to the

Colorado General Assembly

Research Publication No. 187
November, 1972

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL
ROOM 46 STATE CAPITOL
DENVER, COLORADO 80203
892-2285
AREA CODE 303

November 27, 1972

To Members of the Forty-ninth Colorado General Assembly:

As directed by House Joint Resolution No. 1033, 1971 Session, the Legislative Council appointed a committee to make a two-year study of hospital rates and related matters. The Committee on Hospitals presented a report of findings and recommendations from its second year of study to the Council on November 27, 1972. At that time the Council approved the report for transmission to the Governor and the First Regular Session of the Forty-ninth General Assembly.

The Council herewith submits for your consideration Part II of the Report of the Committee on Hospitals.

Respectfully submitted,

/s/ Representative C. P. (Doc) Lamb
Chairman

CPL/mp

COLORADO GENERAL ASSEMBLY

LEGISLATIVE COUNCIL
ROOM 46 STATE CAPITOL
DENVER, COLORADO 80203
892-2285
AREA CODE 303

November 27, 1972

Representative C. P. (Doc) Lamb
Chairman
Colorado Legislative Council
Denver, Colorado 80203

Dear Mr. Chairman:

In accordance with House Joint Resolution No. 1033, 1971 Session, your Committee on Hospitals was appointed to study factors affecting the rising cost of health care, and to submit its findings and recommendations to the Legislative Council. The Committee submits herewith Part II of its report and makes the following recommendations:

(1) Any health care facility must obtain a certificate of need from the Department of Health prior to initiating a construction, expansion, or alteration project, when such project would require a capital expenditure of $100,000 or more. As an additional criteria, such project must require a ten percent or greater increase in the number of beds; a change in health service; a change in licensure category; or the purchase of therapeudic or diagnostic equipment.

(2) Establishment of a fund to assist the development of health education programs by school districts or boards of cooperative services, in order to promote the concept of prevention as a positive approach to good health.

Respectfully submitted,

/s/ Representative Roy H. Shore
Chairman
Committee on Hospitals

RHS/mp

FOREWORD

The Committee on Hospitals conducted a two-year study of the factors affecting the rising costs of health care and during its second year of study, held four meetings. The members appointed to serve on the Committee are:

Rep. Roy Shore,
  Chairman
Sen. Clarence Decker,
  Vice Chairman
Sen. George Jackson
Sen. Norman Ohlson
Rep. Dennis Gallagher
Rep. Wallace Hinman
Rep. Gerald Kopel
Rep. Kay Munson
Rep. Morton Pepper*
Rep. Frank Southworth**

The Committee reconsidered its recommendations in the Part I Report concerning certificate of need and health education. After considerable study, the Committee expanded the scope of the certification process to include all health care facilities rather than limit the application of the certification process to hospitals, as the Committee had previously recommended. Further, the Committee recommended that encouragement be given school districts and boards of cooperative services to establish health education programs in their school curricula through the provision of funds to assist in the development of such programs.

Assisting the Committee in its exploration of the issues surrounding certificate of need was the Colorado Hospital Association, which provided much information to the Committee concerning the effects of various certification proposals on hospital programs. Others who contributed to this study include: students and staff of graduate programs in Health Administration, University of Colorado Medical Center; Comprehensive Health Planning; Colorado Department of Health; Kaiser Foundation Health Plan of Colorado; hospital administrators; and the Colorado Medical Society. Special citation goes to the American Hospital Association (AHA) for granting permission to the Committee to reproduce sections of an AHA report which compares the certification procedures in various states having such legislation.

*Served on the Committee during the 1971 interim.
**Served on the Committee during the 1972 interim.

The Committee's exploration of health education in school curricula was assisted by the Health Education Subcommittee of the Legislative Committee, Comprehensive Health Planning. Representatives of Colorado Blue Cross and Blue Shield appeared before the Committee to review their administrative practices.

The Committee wishes to express its appreciation to these individuals and agencies for their cooperation and assistance in the conduct of this study. The assistance given to the Committee by these agencies contributed immeasurably to the contents of this Part II report.

Mrs. Rebecca Lennahan, assisted by Mr. Mike Risner, provided bill drafting services to the Committee.

Mrs. Kay Miller, research associate on the Council staff, was primarily responsible for the research material compiled by the staff, and was assisted by Mr. David Morley, senior research assistant.

November, 1972

Lyle C. Kyle
Director

TABLE OF CONTENTS

COMMITTEE FINDINGS AND RECOMMENDATIONS

Certificate of Public Necessity for Health Care Facilities

At the conclusion of its first year of study, the Committee on Hospitals recommended that the 1972 Session of the General Assembly be given an opportunity to consider legislation on establishing a requirement that hospitals obtain a certificate of necessity prior to commencing any construction, expansion or modification project. The item was not included on the Governor's Call for the 1972 Session and the Committee has devoted considerable time and further study to this piece of legislation during the 1972 interim. The Committee is strongly committed to the belief that this device of requiring proof of need before the construction or modification commences provides a reasonable method of preventing unnecessary duplication of health care facilities which contributes directly to the high cost of health care.

Function of the Legislation. As outlined in the legislative declaration, the legislation is intended to "...avoid unnecessary duplication by ensuring that only those health care facilities that are needed will be built..." and "to provide an orderly method of resolving questions concerning the necessity of construction or modification of health care facilities". The legislation is designed to provide that the decision-making process will involve consumers and "providers" in the locality to be affected by the proposal. Local input is accomplished by requiring that proposals be initially considered through the mechanism of the area wide comprehensive health planning agency which serves the area in which the proposed construction or modification is to take place. These area wide agencies are established in accordance with the provisions of Public Law 89-749. The federal act, commonly referred to as the Comprehensive Health Planning Act, requires that the advisory councils of the CHP (Comprehensive Health Planning) agencies be comprised of a majority of consumers.

The proposed legislation would insure input from persons and facilities affected at the local level and allows for public hearings to be conducted in the area when requested. The proposal would require that, in evaluating the merits of the proposal and the need for the construction or modification, such things be considered as: the anticipated effect the proposal will have on existing facilities and on their per day costs; the relationship of the proposal to priorities that have been established for the area to be served; the possible economies and improvement in service that might be derived from operation of joint, cooperative or shared health care resources; and a host of other factors.

Scope of the legislation. In its 1971 recommendations to the General Assembly, the Hospital Committee proposed that hospitals be required to receive a certificate of public necessity prior to commencing a construction, expansion or modification project. After further testimony and deliberation, the Committee now recommends that such a requirement apply not only to hospitals but be applied to any health care facility which is licensed or certified by the Department of Health. This definition includes almost the full range of health care facilities ranging from hospitals to nursing homes, mental health centers, rehabilitation centers, etc. It includes facilities operated by the state and its political subdivisions and for-profit as well as non-profit facilities. Federal facilities are outside of the state's jurisdiction.

The Committee reasoned that all types of health care facilities are related and have an impact on each other and the entire health care system. To require only one component of the system, such as hospitals, to comply would not achieve the intent of the legislation. One serious problem in the health care field has been the traditional way of viewing it as a series of fragmented, unrelated facilities and services--a "non-system" as it has been called. This bill encourages the attitude of perceiving each facility and service as an integral segment of a total health care system.

Agency Responsible for Certification. The Hospital Committee deliberated at length concerning what agency should be given final authority to issue or deny a certificate of necessity. For the most part, the discussion revolved around whether the State Health Department or the Office of Comprehensive Health Planning is the more appropriate agency to be given this responsibility. In addition, the Colorado Hospital Association, which actively participated in all of the Committee discussions, proposed that a new health commission be established within the Department of Health to be ultimately charged with reorganization of the entire health care delivery system. The Hospital Association envisioned such a commission as being initially concerned with planning and the certificate of need procedure. The Committee decided that the existing machinery in state government provide an adequate mechanism to accomplish the certification procedure without creating a new governmental agency.

While the Committee agreed that comprehensive health planning, particularly the area wide CHP agencies, should be integrally involved in the certification of need procedure, it concluded that the Department of Health, through its present duties and functions, is well equipped and staffed to assume the certifying function. The department is currently responsible for inspecting and licensing all health care facilities.

The department is also the agency designated to administer the state plan for hospitals required for Hill-Burton funding and the plan required for mental health and mental retardation construction funds. In this capacity, the department is assisted by a statutory State Health Facilities Advisory Council (see 66-18-2, C.R.S. 1963 (1965 Supp.)). The Committee decided that with this expertise and machinery already present, the Health Department would be the logical agency in which to vest final authority for certificate of need.

Certificate of Need Required - When. One of the most difficult and highly debatable questions with which the Committee had to deal is that of "what activates the certificate of need procedure?". It was the intent of the Committee to establish realistic criteria which would insure that any modification which substantially affects the nature or scope of the facility's health care program would be covered but that routine "housekeeping" changes and non-health related modifications would not be included in the process. For this reason, the Committee drafted language which would provide that two conditions be present before a certificate of need would be required. The proposed project would have to involve a capital expenditure of $100,000 and at least one of the following factors:

a) a change in health service;

b) a ten percent or greater increase in the number of beds;

c) a change in licensure category;

d) the purchase or acquisition of diagnostic or therapeutic equipment.

Not all Committee members agreed with the $100,000 capital expenditure amount and proposed a figure of $25,000, arguing that having two conditions present prior to activating the certification process would provide adequate safeguards against requiring certification for routine expenditures. However, by a vote of 3-2, the Committee is recommending the $100,000 figure.

Financing the Certification Process. While some states have chosen to finance the certification process through an assessment on the health facilities, the Committee believes this is a procedure that will benefit all citizens and therefore should be financed through the state General Fund. However, the Committee is of the opinion that there is adequate personnel on board in the Comprehensive Health Planning agencies and the Department of Health to implement the procedure

without the addition of personnel. The Executive Budget Office has asked departments to anticipate upcoming legislation in their budget requests. In connection with the pending certificate of need proposal, the Health Department has projected that it would need an additional planner and a statistical clerk at a cost of $21,300. However, these are positions the department is requesting in its regular budget even if the proposal is not implemented but believes would be essential if the certificate of need legislation is passed.

Public Hearing. The Committee's rationale surrounding several other items probably deserves mention. Regarding the role of the public hearing, the Committee decided that rather than require a public hearing at the local level on each application for a certificate, hearings should be conducted only when requested or on the initiative of the area wide CHP agency. This would eliminate the necessity of conducting a hearing on more routine matters about which there might be little controversy. Public hearings are automatically required on decisions that are appealed.

Appeal Procedure. Since the initial decision to issue or deny a certificate of need will likely be made by staff of the Department of Health, perhaps assisted by the State Health Facilities Advisory Council, it appeared reasonable that contested decisions should be appealed to the State Board of Health, a citizen board. Appeals may be made either by an aggrieved applicant or by more than one-third of the members of the area wide CHP agency if the decision of the department is contrary to the recommendation of the area wide agency. The Committee believes that if the department overturns the recommendation of the area wide agency which is close to the proposal and represents the area to be affected, the decision should be reviewed by an impartial body if requested by the area wide agency.

Time Limit on Certificate. The Committee suggests that twelve months is a reasonable length of time to allow a health facility to commence a project before its certificate of necessity expires. However, realizing that there are reasonable causes for delay, the proposed bill spells out a procedure for extending the time period and has provision for emergency situations beyond the applicant's control which might cause an unforeseen delay.

Sanctions Against Non-Complying Facilities. The proposed bill gives the department several tools of enforcement of the certification requirement. First, the department is authorized to seek an injunction to halt the construction or modification of any health facility for which the required

certificate has not been issued. Secondly, the department can deny or revoke the license of any non-complying facility, which has the effect of shutting the facility down. The department, which is the state agency which allocates Hill-Burton and other health care facility construction funds, can withhold public funds from non-complying facilities. Finally, proceeding with a construction or modification project without first obtaining the required certificate would constitute a misdemeanor under the proposed bill, punishable by a five-hundred dollar fine.

Additional Authority. The Committee deliberated at length concerning the role of the department in eliminating duplication in existing facilities and taking an active role in developing facilities and manpower in areas of shortage. While there is some sentiment that the state agency should be empowered to shut down duplicative services, the Committee is encouraged by the voluntary efforts that are being made to eliminate duplication through cooperative programs and shared services, etc. Therefore, the Committee suggests that the Department of Health, in conjunction with the state and area wide CHP agencies, lend their assistance in recommending and encouraging these types of efforts. However, the Committee does recommend that the department submit an annual report to the General Assembly to include recommendations for statutory changes which may be necessary or desirable to implement such programs.

Health Education Proposal

The health education proposal which the Committee is recommending would not mandate the implementation of health education programs in every school district in the state, but rather seeks to provide incentives and assistance to those districts which have included or desire to include health education in their curricula. This health education proposal is not intended to provide direct health services to the schools but rather to assist in the development of health instruction programs to include such subjects as personal health practices, the effects of behavior modifying substances such as drugs and alcohol, environmental health, control of communicable diseases, etc.

Assistance to Local School Districts and BOCS. The proposed bill authorizes the Department of Education to make grants to local school districts and boards of cooperative services (BOCS) for health education programs. It is intended that the advisory council, created by the bill, will establish priorities for distribution of funds under the

proposal. The bill itself instructs the department in evaluating school health education programs for assistance grants to give priority to those "programs which provide a comprehensive range of health programs and evidence a high degree of community support, either financial or in the furnishing of services and facilities, or both...".

Evaluation. The bill has a built-in assurance of program evaluation. The bill stipulates that of the amount distributed to school districts and BOCS under the provisions of the bill, at least six percent shall be used for program evaluation. The amount could either be included in the grant to the school district for self-evaluation or withheld for evaluation by the department or dedicated to some other form of outside evaluation.

Duties of the Department. In addition to authorizing the department to make grants to school districts and BOCS for health education, the proposed bill instructs the department to provide numerous other services which the Committee believes will be of benefit in the development and upgrading of health education programs throughout the state. Among the services and duties the department is instructed to perform are: 1) developing requirements for certification of health education teachers; 2) coordinating in-service training for teachers; 3) providing consultive services to school districts in planning, managing and evaluating their health education programs; 4) developing a resource library on health education, etc.

Appropriation. The Committee believes that the implementing legislation should include an appropriation to cover the cost of administering the program and provide a fund to be used for grant assistance to the schools. The Health Education Subcommittee of the Legislative Committee, State Health Planning Council, which submitted the proposal to the Committee, suggested an appropriation of $275,000. However, the Committee believes that in the regular standing committee hearings during the session more time and testimony should be devoted to the question of the amount of appropriation necessary to adequately implement such a program.

CERTIFICATION OF NEED

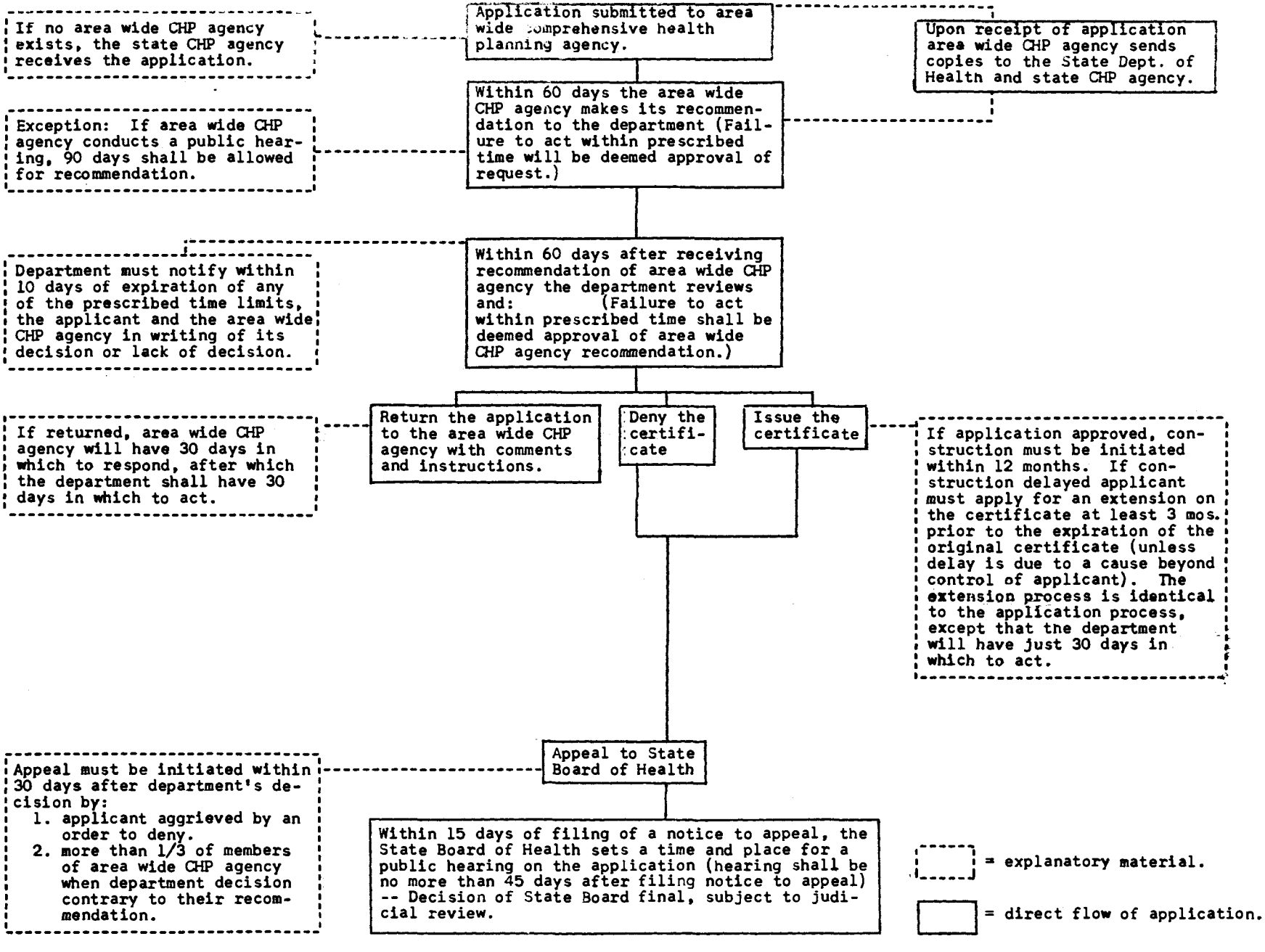
COLORADO PROPOSAL AND SURVEY OF OTHER STATES

In discussing the concept of certification of need and designing a plan for the State of Colorado, the Committee on Hospitals gave consideration to similar legislation which has been introduced or enacted in other states. The Committee paid particular attention to how other states attempted to deal with the broad issues that must be addressed in the implementing legislation -- i.e., scope of coverage, how the certification process is initiated, the application and review process, etc. In a sense the Committee bill is a composite of many other bills. The Committee attempted to pick and choose ideas and approaches that were applicable and adaptable to Colorado's situation as well as designing its own plan when no appropriate model was available.

A report compiled by the staff of the American Hospital Association entitled Survey Report: Review of 1971 State Certification of Need Legislation was of particular assistance to the Committee and its staff. Because of its usefulness, part of this report has been included herein. This particular part provides a descriptive analysis of 33 certificate of need bills which had been enacted or defeated or were still pending at the time the report was written. Additionally, it outlines the overall patterns and trends that are beginning to emerge in certificate of need legislation.

For purposes of comparing the Hospital Committee proposal with legislation in other states, the succeeding page is a flow chart of the certification process as contemplated in the Hospital Committee bill. The chart tracks the process from the point of application through the appeal and extension procedure.

FLOW CHART OF CERTIFICATION OF NEED PROCEDURE AS CONTEMPLATED BY THE HOSPITAL COMMITTEE BILL



Prepared by
Legislative Council Staff

SURVEY REPORT

REVIEW OF
1971 STATE CERTIFICATION OF NEED LEGISLATION

Reprinted, with permission of
the American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
(4M-3/72-2370, pp. 1-16).

PART I

Analysis of Legislative Patterns

Prior to 1966 there was little hope for imposing a rational or comprehensive order on the diverse and often chaotic methods of providing health care to the citizens of the United States. Various individuals and organizations had attempted to devise some type of voluntary compliance with planning theory and practice, but there were few agencies in existence and planning theory itself was not well formulated. The Comprehensive Health Planning and Public Health Services Amendments (P.L. 89-749) of 1966 sought to remedy part of this dilemma by establishing a mechanism for the creation and financing of health planning agencies and for the development of a body of theory that could be used by these groups. However, as before, it was not mandatory for the industry to cooperate in this process, although various motivations, such as withholding of government funds, were used to induce compliance when any part of the system sought to apply for financial assistance.

In the same year the federal legislation was enacted, New York passed a law that was later to provide a possible though still only partial solution to the growing tide of the public's and industry's concern over the rising cost of health care and its commonly argued cause--poor planning of facilities and services. Article 28 of the New York Public Health Law mandates that no construction of a private or public hospital shall be commenced without the prior approval of the state commissioner of health, the designated state hospital review and planning council, and the appropriate regional hospital planning council. The approval is called a "certification of need" and provides the mechanism for ensuring that the health care industry shall expand only in accordance with formulated plans that seek to provide accessibility and availability of health care to the greatest number of people.*

Other states soon recognized the value of such legislation. By 1969, 17 states reported that such measures had been either enacted or introduced into their legislatures. In the next year, 10 states recorded certification-of-need activity. And in 1971, 33 states reported activity, although several proposals were reintroduced bills signifying the concentrated interest and efforts of some states to have such a procedure in their statutes. (See Chart 1 p. 2)

This review showed that, as of August 1971, 14 states had officially enacted such measures: Arizona, California, Connecticut, Maryland, Minnesota, Nevada, New Jersey, New York, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, and Washington. At the same time, 10 states were awaiting the action of their legislatures: Georgia, Illinois, Iowa, Massachusetts, Michigan, New Hampshire, North Carolina, Pennsylvania, Texas, and Wisconsin. Unfortunately, some of these legislatures do not meet every year, and the bills therefore will be delayed until 1973. Proposals in nine states failed to pass: Florida, Hawaii, Idaho, Indiana, Kansas, Mississippi, Montana, New Mexico, and South Dakota.

*The word "franchising" is sometimes seen in the literature but was used in only one of the 35 bills analyzed. Because there seems to be no clear distinction between the words "franchising" and "certification," this analysis will use only the latter word.

CHART 1

STATUS OF CERTIFICATION LEGISLATION, 1971

STATE	ENACTED	YEAR ENACTED	PENDING	DEFEATED
Arizona				
California				
Connecticut				
Florida				X
Georgia			X	
Hawaii				X
Idaho				X
Illinois			X	
Indiana				X
Iowa			X	
Kansas				X
Maryland				
Massachusetts			X	
Michigan			X	
Minnesota				
Mississippi				X
Montana				X
Nevada				
New Hampshire			X	
New Jersey				
New Mexico				X
New York				
North Carolina			X	
North Dakota				
Oklahoma				
Oregon				
Pennsylvania*			X	
Rhode Island				
South Carolina				
South Dakota				X
Texas			X	
Washington				
Wisconsin			X	

***NOTE:** Pennsylvania's bill has been drafted but no activity has actually taken place in the legislature. It is included because this one version is in final form for introduction.

CHART 2

CHANGES NECESSITATING APPLICATION FOR CERTIFICATION

STATE	FACILITY CONSTRUCTION	MINIMUM CAPITAL EXPENDITURE	CHANGE IN MINIMUM NUMBER OF BEDS	CHANGE IN SERVICE	LICENSURE
Arizona	X				
California	X				
Connecticut	X				
Florida	X	100,000	1+		
Georgia	X				
Hawaii	X		1+		
Idaho	X	100,000			
Illinois	X			X	
Indiana	X		10 or 5%		X
Iowa	X	100,000	1+		
Kansas	X	350,000	1+		X
Maryland	X				X
Massachusetts	X	250,000			
Michigan	X		1+	X	X
Minnesota	X				
Mississippi	X		50%		X
Montana	X	50,000			
Nevada	X				X
New Hampshire	X	100,000		X	X
New Jersey	X				X
New Mexico	X	100,000		X	X
New York	X				X
North Carolina	X		1+		X
North Dakota	X		1+	X	X
Oklahoma	X				X
Oregon	X			X	X
Pennsylvania	X	250,000		X	
Rhode Island	X				X
South Carolina	X			X	X
South Dakota	X		1+		X
Texas	X		1+	X	X
Washington	X				
Wisconsin	X	100,000	1+		X

Many of the bills or laws are similar, but there is no absolute formula by which the states abide in their legislative interpretations of the certification-of-need process. Some certificates are linked to the licensure process, some rely on the denial of state and federal funding, and a few resorting to court action in the case of infringement. For the most part, certification is a control or regulatory function that is added to the existing health planning process.

Initiating the Certification Process

The certification process relies primarily on the institutions to propose a change in facilities or service. In other words, it is reactive. The questions of which changes would have a major impact and therefore should be certified and which would have a minor impact and need not be, have generated much thought and various proposals but no clear-cut answers. The laws reviewed showed five general approaches. (See chart 2 p. 3)

1. Every one of the 33 states reporting specified that a certificate was mandatory for the construction of facilities, and almost all of them included additions, expansions, alterations, and conversions.

2. Only 15 of the bills indicated a mandatory dollar figure that required an application for certification. The range was from $10,000 to $350,000, and the average was about $130,000. These bills not delineating the amount of capital expenditure either relied on the regulations when they were written or specified that any major construction necessitate an application (but did not define "major construction").

3. An alternative to a dollar amount was a specification as to the number of beds that could be added without approval. Generally the bill simply stated that the addition of any beds necessitate such a procedure. The California bill indicated that the addition of six or more beds necessitated a certificate, the Indiana bill specified 10 beds or 5 per cent of the present complement, and the Mississippi bill permitted a change of 50 per cent.

4. The fourth factor is the most difficult to assess because it is implied in almost all the bills but stated explicitly in only 14 of the 33 bills reviewed. These 14--eight of which already are enacted--listed a change in service or provision of new services as a qualifying factor for initiation of application procedures. A few bills attached

such change to the dollar amount of capital expenditure, but the majority merely stated that a "major change" in health care services was enough to warrant the prior-approval process. The difficulty is that almost any major construction or renovation will in some way change the service pattern of the institution, but it is conceivable that a situation might arise in which the capital expenditure is not over the allowable limits, no beds are being added, and yet a major service is being instituted or changed in some way. If the bill does not state that such a situation comes under the statutes, needless duplication may occur. Unfortunately, only a few states have drafted complete sets of guidelines, and, until the others do so, it will not be possible to determine whether such loopholes are going to be closed.

5. Nineteen of the bills directly mentioned licensure--either application for, renewal of, or a request for a change in the category of a license--as sufficient for a mandatory application for certification. This would make the certificate an absolute necessity if the hospital were to begin or continue operations, and it is one of the most effective means of guaranteeing compliance with the concept of area-wide comprehensive health planning. In fact, several states have made the certification-of-need process a subsection of their health facilities and services licensure regulations, thus covering all situations that would affect the licensure status of the provider. The difficulty inherent in this analysis is the fact that the agency that most often grants the certificate also grants the license, and it is probable that nearly every state will have a regulatory provision in its guidelines stating that lack of prior certification will be cause for denial or revocation of the license. This makes it extremely difficult to separate the two activities for adequate analysis.

A further point regarding licensure and certification is that one or two states indicated that their particular licensure laws were sufficient to guard against unnecessary expansion or construction. It is possible that these particular states do not have serious problems with excessive construction or expansion and therefore the existing licensure laws are adequate. However, this was not true for many other states, which found it necessary to completely rewrite their laws to include the provisions for certification.

Scope of Coverage

There was diversity also in the types of facilities that require certification. In 60 per cent of the states reviewed, all facilities

CHART 3
SCOPE OF COVERAGE, FACILITIES

STATE	ALL PRIVATE HOSPITALS	LONG-TERM CARE FACILITIES	NONFEDERAL GOVERNMENTAL HOSPITALS	ALL NONFEDERAL HEALTH CARE FACILITIES	OTHER
Arizona				X	
California				X	
Connecticut				X	
Florida				X	
Georgia				X	
Hawaii				X	
Idaho				X	
Illinois				X	
Indiana	X	X			
Iowa				X	
Kansas	X	X			
Maryland	X		X		X
Massachusetts	X	X			X
Michigan				X	
Minnesota				X	
Mississippi				X	
Montana	X	X			X
Nevada					
New Hampshire	X	X			
New Jersey				X	
New Mexico					
New York	X	X			X
North Carolina				X	
North Dakota					
Oklahoma					
Oregon					
Pennsylvania				X	
Rhode Island					
South Carolina					
South Dakota				X	
Texas	X		X		
Washington					
Wisconsin				X	

except federal were covered by the certification process and were enumerated in the preliminary "definitions" section. It is with the other 13 bills, especialy those that specify coverage only for health care facilities licensed under a certain section of a state's public health laws, that some problems arise in delineating the precise coverage intended.

In other cases, different states utilized different terms for classifying institutions. For example, one state stipulated merely "long-term care facilities," but most others categorized the types of facilities and clearly identify the exclusions that are intended.

Because of these difficulties, five classifications generally are used in this report: private hospitals, nonfederal (state and local) governmental hospitals, long-term care facilities, all nonfederal health care facilities and other. (See Chart 3 p. 6) The last category is used when only certain specific subcategories are qualified, such as "governmental hospitals except those for treatment of the mentally ill" or "long-term care facilities except those for custodial care or long-term psychiatric care."

As shown in the appropriate matrix chart 3 on page 6, six bills covered private hospitals and long-term care facilities and four bills included both private and governmental hospitals but not long-term facilities. Four states made specific exclusions.

One state, Oklahoma, passed a certification-of-need bill for "skilled nursing homes, intermediate care facilities, and specialized homes" but for no other classifications. It was reported that after this bill was enacted and signed into law an effort was made to draft an amendment that would broaden the scope of the law to include other types of facilities and services. Oklahoma is the only state in which this step of graduated implementation has been taken, although others purportedly will seek to make their coverage more inclusive.

Twenty bills contained coverage for "all nonfederal health care facilities." This probably will continue to be the general trend as more states introduce and enact certification bills.

Application and Review Process

A preference was indicated for a three-step procedure in the formal certification-of-need process. Although only eight bills specifically called for local (city or county) planning agency

CHART 4

APPLICATION AND REVIEW PROCESS, AGENCIES INVOLVED
(Circle indicates agency that grants certificate)

STATE	LOCAL PLANNING AGENCY (City or County)	REGIONAL PLANNING AGENCY (Areawide or CHP)	PUBLIC HEARING	STATE CHP OFFICE	HILL-BURTON	STATE DEPARTMENT OF HEALTH OR EQUIVALENT	OTHER
Arizona		X				O	
California	X	X	X	O	X		
Connecticut						O	
Florida		X	X	X	O	X	
Georgia		X				O	
Hawaii		X				O	
Idaho		X		X		O	
Illinois		X		X		O	
Indiana	X	X				O	
Iowa	X	X	X	X		O	
Kansas		X		X		O	
Maryland		X	X	X		O	
Massachusetts		X		X		O	
Michigan	X	X		X	X	O	
Minnesota		X	X			O	
Mississippi						O	
Montana		X		X		O	
Nevada		X		O		X	
New Hampshire	X	X		X	X	O	
New Jersey	X	X	X	X		O	
New Mexico		X		X		O	
New York		X			X	O	
North Carolina		X				O	
North Dakota		X		X		O	
Oklahoma						O	
Oregon		X		O		X	
Pennsylvania		X		X		O	
Rhode Island		X				O	X
South Carolina	X	X		X		O	
South Dakota	X	XX	X	X		O	
Texas		X		X		O	
Washington		X				O	
Wisconsin		X		X		O	

approval as the first step, 29 bills made it mandatory that the application be reviewed by the areawide or regional planning agency. Several mentioned a public hearing, although this could take place before any one or any combination of designated review bodies. (See Chart 4 p. 8)

The next most frequent step was approval by the state comprehensive health planning (CHP) agency or board. In California and Nevada, this unit was given the final authority to grant the certificate before the application proceeded further for licensure. In several bills the state comprehensive health planning agencies were not specifically mentioned, because they are within the state department of health; thus they would be an integral part of the process as a matter of course. This same logic applies to the designated Hill-Burton agencies, although they were explicitly named only five times, and only in Florida's defeated bill were they given authority to grant the certificate.

This multiorganizational integration causes difficulties in an analysis of the succession of review steps and generally makes it necessary to await guidelines before it is possible to delineate actual process.

As might have been expected, every bill named the state board of health or its equivalent as a primary agency in the review and comment on the application. As stated earlier, the certification process thus has a close relationship with the licensing mechanism, because the health department was the licensing agency in each of the states. Also, the fact that in 28 states the health department was the agency with the final authority to grant the certificate ensured overall coordination of the review-and-comment role played by the other organizations in the process.

As to which unit or group within the department of health was given the certification authority, there was no unanimity. Many bills simply stated that such powers will be vested within the department. Other bills stipulated a particular unit, such as "division of hospitals" or "council of health and hospitals." Florida specified "hospital and medical facilities construction agency."

Several states created a special organizational unit for the certification process. This could be an advisory board to the commissioner of health, or it could be some other body named by the governor of the state. Each of these, however, was an integral part of the department, and it is expected that forthcoming guidelines will enumerate the various duties and relationships that these special units are expected to establish and maintain.

The certification process need not proceed in the order of review herein described. In fact, many states stipulated that the application for certification was to be sent first to the department of health, and that the agency would either forward copies of the application to the various designated review bodies or would ask the applicant to submit simultaneous applications to the department and to the regional planning agency and/or the state comprehensive health planning agency. This would shorten the processing time, because different review bodies would be working at the same time and their recommendations could be sent to the certifying authority nearly simultaneously.

However, not all the agencies mentioned necessarily need to comment on the application. In several states the areawide planning agency would review the request and send its recommendations and comments to the state comprehensive health planning agency, which could review and comment itself or merely send the areawide agency's consideration directly to the next level. Thus, if the state agency concurred with the regional body, the processing time could be shorter. This is not merely an informational step, because at any time the state planning agency could make its own recommendations, either amending or contradicting the areawide agency's comments.

In only four states did the bills bypass all other agencies and place the review and approval responsibility totally on the board of health. Although these bills stipulated that the board could request advice from various government and voluntary organizations, such a request was not mandatory. However, it is likely that regulations will provide further guidelines in which the boards will be directed to seek other expert opinion when there is any question concerning a request.

There is a possibility that some applicants may be granted a certificate of need automatically. Most of the bills set time limits within which the various agencies had to complete their task of review and recommendation, although the consequences of failure to do so were not specifically stated. In five states, however, the bills explicitly state that, if the certifying agency did not arrive at a final decision within the time allowed, endorsement of the proposal would be assumed and the applicant could proceed. (See Chart 5 p. 11)

Of the five states-California, Connecticut, Maryland, Kansas, and North Dakota-with such a provisco, four already have enacted bills. Kansas failed to have its bill signed into law.

Appeal Process

Although five bills did not state the precise method by which an applicant could appeal and have his request reinvestigated and

CHART 5

TIME LIMITATION INVOLVED IN CERTIFICATION

STATE	CERTIFICATES AUTOMATICALLY GRANTED IF NOT ACTED UPON WITHIN SPECIFIED PERIOD	LENGTH OF TIME CERTIFICATE IS VALID		
		SPECIFIED TIME FOR HOSPITALS (in months)	VARIABLE	NOT SPECIFIED
Arizona				X
California	X	12		
Connecticut	X			X
Florida		6		
Georgia		12		
Hawaii		12		
Idaho				X
Illinois				X
Indiana				X
Iowa				X
Kansas	X	12		
Maryland	X	12		
Massachusetts			X	
Michigan				X
Minnesota		12		
Mississippi				X
Montana		12		
Nevada				X
New Hampshire				X
New Jersey		12		
New Mexico		18		
New York		6		
North Carolina		24		
North Dakota	X		X	
Oklahoma		6		
Oregon				X
Pennsylvania		24		
Rhode Island				X
South Carolina				X
South Dakota				X
Texas		12		
Washington		24		
Wisconsin				X

CHART 6
APPEAL PROCESS

STATE	INITIAL APPEAL AGENCY	FINAL APPEAL AGENCY	NOT SPECIFIED
Arizona	State Department of Health	State Department of Health	
California	Areawide Planning Agency	State CHP Office	
Connecticut			X
Florida	Hill-Burton Agency	State Department of Health	
Georgia	State Department of Health	Superior Court	
Hawaii	State Department of Health	Courts	
Idaho			X
Illinois	State Department of Health	State Department of Health	
Indiana	State Department of Health	Courts	
Iowa		District Court	
Kansas	Appeals Board	District Court	
Maryland		Courts	
Massachusetts	Appeals Board	Courts	
Michigan	State CHP Office	Courts	
Minnesota	Appeals Board	Courts	
Mississippi			X
Montana	State Department of Health	State Department of Health	
Nevada	State CHP Office	State CHP Office	
New Hampshire	Department of Health & Welfare	Courts	
New Jersey	State Department of Health	State Department of Health	
New Mexico	State Department of Health	Courts	
New York	State Department of Health	Hearing Board	
North Carolina	State Department of Health	Courts	
North Dakota	State Department of Health	Courts	
Oklahoma	Health Facilities Advisory Council	State Department of Health	
Oregon			X
Pennsylvania	Department of Public Welfare	Courts	
Rhode Island	State Department of Health	Courts	
South Carolina	State Department of Health	Courts	
South Dakota		Courts	
Texas	State Department of Health	Courts	
Washington			X
Wisconsin	Department of Health & Social Services	Courts	

reappraised, 28 bills did detail the procedure. The majority said that the initial appeal would be made to the agency that had the responsibility to grant the certificate, and, if this did not suffice, it would be necessary to seek a court decision. In almost all the cases in which a license depended on the granting of certification, this was the procedure, and the precise method of initiating the proceedings was indicated in the state statute. (See Chart 6 p. 12)

However, there were other ways in which the applicant could appeal the decision of the certifying or reviewing agency. In California, the state planning agency would designate an alternate regional planning agency to hear the applicant's protest if the original decision of his designated regional agency was to be contested. After that, the state planning council would hear the final appeal and make the binding decision.

In Florida, the initial appeal would be made to the Hill-Burton agency, and the final appeal would be taken to the state board of health. Three states sought to establish a special board that would review the first appeal, after which the applicant would have recourse to the judicial system. A final appeal to the appropriate court was a provision of 19 of the bills.

Time Limitation of Certificate

Because community and regional needs vary with the passage of time, many states specified that the approval would be valid for a specified period, although the period could be modified if an investigation disclosed a valid reason for an extension. (See Chart 5 p. 11)

Sixteen bills stipulated that the certificate would be in effect for a certain number of months. (The range was between six and 24 months, although one year was most frequently stipulated, and the average was only slightly more than one year.) Three bills would allow two years for a demonstration of a concerted effort to complete the project, and two bills had a limitation of six months.

Although the North Dakota and Massachusetts bills stated that there was a limitation, they did not state a particular length of time. This was to be decided by the certifying agency if it determined that the applicant had not complied with the original plans. Fifteen states had no provisions for time limitations on certificates.

Financing the Certification Process

Eight states sought to help finance the approved procedure through application fees, although not all the bills specified the precise

amount. For those that did name a figure, the range was from $20 to $1,000.

Only one state specified that it would finance its certification process through an assessment of licensed health care facilities in order to aid the areawide and regional planning agencies in their duties. California's bill was passed this year and has set an assessment of $4 per year per licensed bed; this will raise approximately $1 million for planning agency support.

The bills of seven states would provide for the use of appropriate state or state and federal funds, although state and federal funds were specified in only two enacted laws, those of Maryland and Washington. The other 17 bills, seven of which are now law, did not specify a process for financing the implementation of certification of need. However, most of those bills have placed final authority for this process in the state department of health or its equivalent; thus funding probably will be derived from appropriations made to finance their total operation.

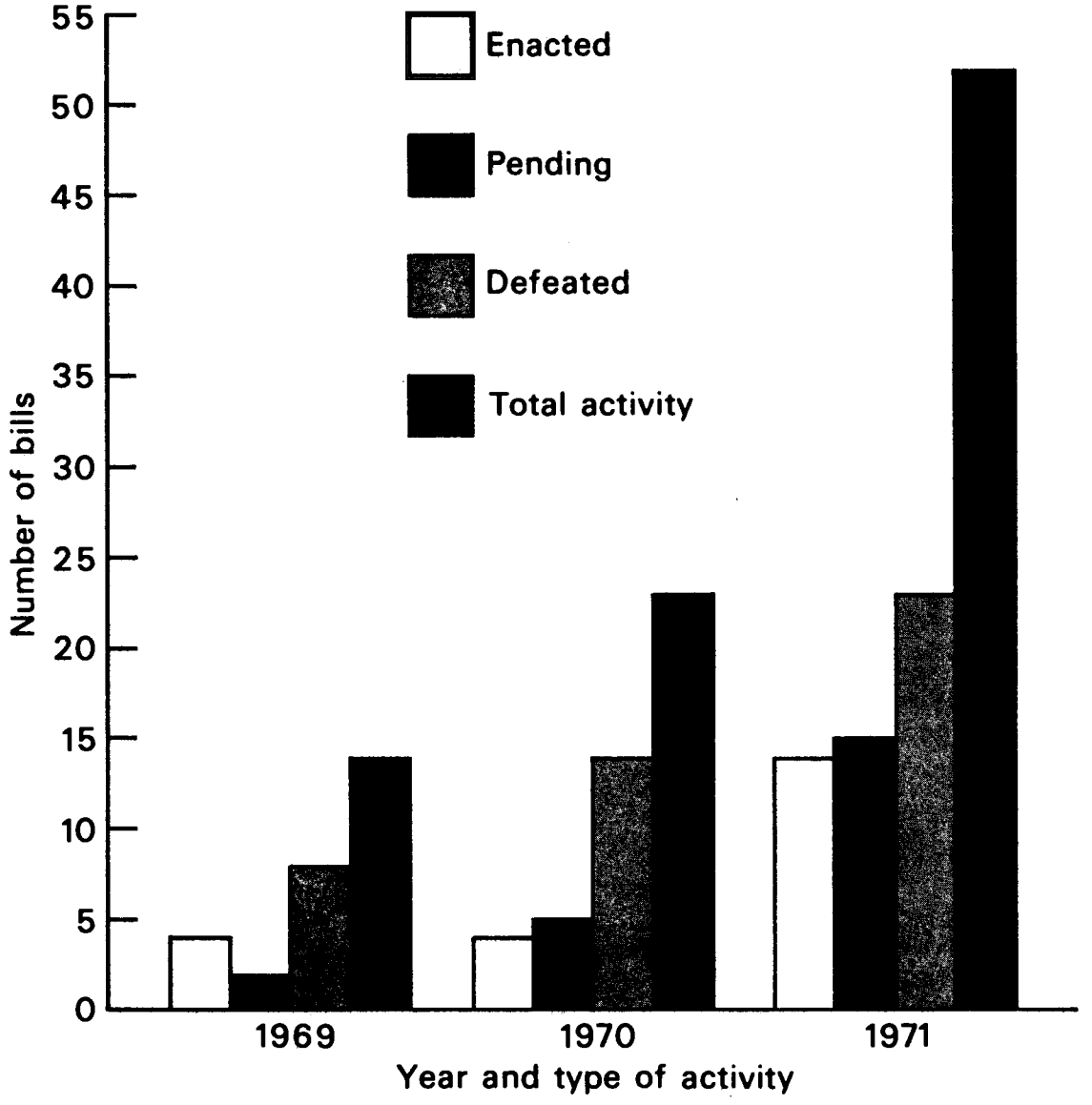
Legislative Coverage of the States

The map on page 16 shows how widespread the certification-of-need legislation activity was in 1971, but it does not relate the entire impact of such proceedings. For those 14 states in which certification legislation is law, 2,208 hospitals are covered; this represents 30 per cent of the hospitals in this country. The same laws involved 559,800 hospital beds, or 34 per cent of the total.

This is rather significant, considering the broad impact of such legislation and the short time that has elapsed since the first bill was enacted in New York. Further, legislative activity is increasing rapidly, as can be seen in the bar graph, page 15. In three years 52 bills have been introduced. Although only 14 bills had been enacted at the time of the survey, this is an increase of almost 250 per cent in only three years.

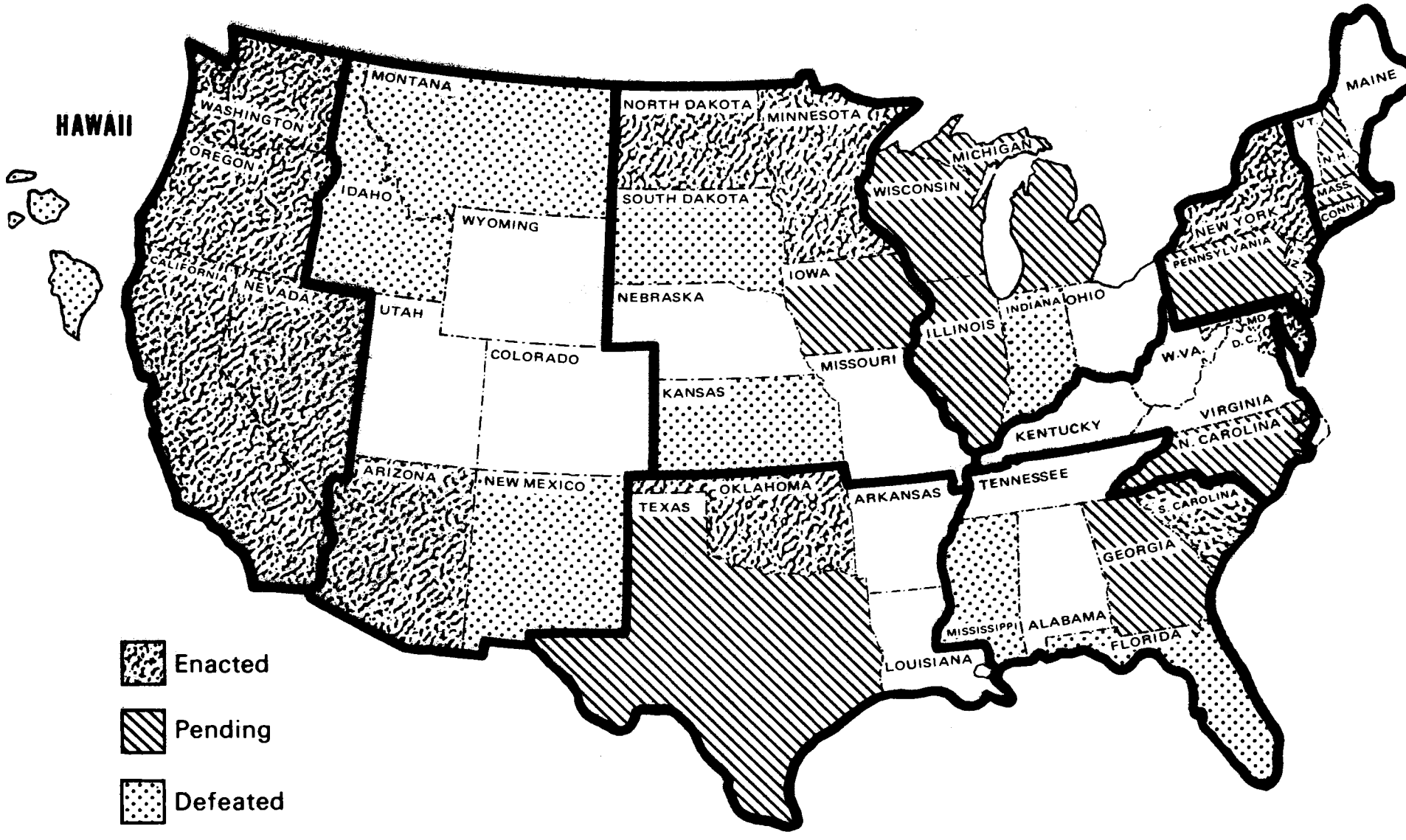
CUMULATIVE CERTIFICATION-OF-NEED LEGISLATIVE ACTIVITY

1969--1971



NOTE: This graph represents the cumulative activities of legislation over a three-year period. For example, pending legislation was reported as two bills in 1969 and three bills in 1970--bringing the total to five--and 10 bills in 1971, giving a final total of 15 bills having been introduced but not voted in or out of the legislatures during the three years.

STATUS OF CERTIFICATION-OF-NEED LEGISLATION, 1971



BILL A

A BILL FOR AN ACT

CONCERNING CERTIFICATES OF PUBLIC NECESSITY FOR HOSPITALS AND CERTAIN OTHER HEALTH FACILITIES.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Chapter 66, Colorado Revised Statutes 1963, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 38

CERTIFICATES OF PUBLIC NECESSITY

66-38-1. Short title. This article shall be known and may be cited as the "Colorado Certificate of Public Necessity Act".

66-38-2. Legislative declaration. The general assembly finds that the unnecessary construction or modification of health care facilities increases the cost of care and threatens the financial ability of the public to obtain necessary medical services. The purposes of this article are to promote comprehensive health planning as contemplated by federal Public Law 89-749, as amended; to assist in providing the highest quality of health care at the lowest possible cost; to avoid unnecessary duplication by ensuring that only those health care facilities that are needed will be built; to provide an orderly method of resolving questions concerning the necessity of construction or modification of health care facilities; to reduce

or eliminate existing duplication and shortages of health care facilities and manpower whenever possible; and finally, to recognize that the coordinated development of health care facilities and services, of desirable size and location, which are responsive to the legitimate needs of consumers, providers, and governments, and the encouragement of more efficient, economical, and effective systems for organizing, financing, and providing health care are worthy goals.

66-38-3. Hospitals and health facilities - certificate of public necessity required - when. (1) (a) On and after January 1, 1974, a certificate of public necessity from the department of health, referred to in this article as the "department", shall be required for:

(b) The construction of any new hospital or health facility for which the department of health is required to issue a license or certificate of compliance pursuant to the provisions of section 66-1-7 (13);

(c) (i) Any modification of a hospital or health facility specified in paragraph (b) of this subsection (1), which modification involves a capital expenditure of one hundred thousand dollars ($100,000) or more and at least one of the following factors:

(ii) A change in health service;

(iii) A ten percent or greater increase in the number of beds;

(iv) A change in licensure category;

(v) The purchase or acquisition of diagnostic or therapeutic

equipment.

66-38-4. Application for certificate of public necessity - procedures. (1) (a) An application for a certificate of public necessity shall be submitted to the area wide comprehensive health planning agency serving the area in which the proposed construction or modification is to take place.

(b) As used in this article, "area wide comprehensive health planning agency" means an agency established to meet the requirements of federal Public Law 89-749, as amended, and designated as such by the state comprehensive health planning agency.

(c) If there is no area wide comprehensive health planning agency which has been so designated as provided in subsection (b) of this subsection (1) in the area to be affected by the proposal, the state comprehensive health planning agency shall perform the functions and duties of an area wide comprehensive health planning agency as they relate to certification of public necessity in that area.

(2) Upon receipt of the application, the area wide comprehensive health planning agency shall send a copy to the department and to the state comprehensive health planning agency.

66-38-5. Contents of application - minimum requirements. (1) (a) Every application for a certificate of public necessity shall include at least the following information:

(b) The general geographic area to be served;

(c) The population to be served, as well as projections of population growth;

(d) The anticipated demand for the facility or service to be provided by the proposal;

(e) (i) A description of the construction or modification in reasonable detail, including:

(ii) The capital expenditures contemplated;

(iii) The estimated annual operating cost, including the anticipated salary cost and numbers of new staff anticipated by the proposal;

(f) Utilization of existing programs within the area that offer the same or similar services;

(g) The anticipated effect the proposal will have on existing facilities and services and on the per day cost of an existing facility;

(h) The anticipated benefit that will result to the area from the proposal;

(i) So far as is known, the relationship of the proposal to any priorities which have been established for the area to be served;

(j) The availability and manner of financing the proposal and the estimated date of commencement and completion of the project;

(k) Availability of manpower and technology to implement the proposal.

(2) The area wide comprehensive health planning agency shall make available to the applicant such information as it may have concerning subsection (1) (f) and (g) of this section.

66-38-6. Recommendation of area wide health planning agency

- time limit. Within sixty days after receiving the application, the area wide comprehensive health planning agency shall make its recommendation to the department; except that if the area wide comprehensive health planning agency holds a public hearing on the application, either on its own initiative or pursuant to the request of any interested party, it shall have ninety days after receiving the application to make its recommendation. The area wide comprehensive health planning agency shall either recommend that the department issue or refuse to issue a certificate of public necessity. The reasons for the recommendation shall be set forth in detail. Failure of the area wide comprehensive health planning agency to act within the required time shall be deemed a recommendation for approval of the application.

66-38-7. Determination by department. (1) (a) Within sixty days after receiving the recommendation of the area wide comprehensive health planning agency, the department shall review the recommendation and make one of the following decisions:

(b) Issue a certificate of public necessity;

(c) Reject the application for a certificate of public necessity;

(d) Refer the application back to the area wide comprehensive health planning agency with comments and instructions for further consideration and recommendations. The area wide comprehensive health planning agency shall have thirty days after receiving the application in which to respond, and the department shall have thirty days after receiving the report of the area wide comprehensive health planning agency to review the

additional findings and either issue or deny a certificate.

(2) If the decision of the department is contrary to the recommendation of the area wide comprehensive health planning agency, the department shall set forth in detail the reasons for reversing the recommendation.

(3) Failure of the department to comply with the time limitations prescribed in subsection (1) of this section shall be deemed approval of the recommendation of the area wide comprehensive health planning agency.

(4) Within ten days after the expiration of any time period prescribed for departmental action, the department shall notify the applicant and the area wide comprehensive health planning agency in writing of its decision or lack of decision on the application for a certificate of public necessity.

66-38-8. Appeal. (1) (a) A decision of the department to issue or deny a certificate of public necessity may be appealed to the state board of health within thirty days after receipt of notice of such decision either by:

(b) The applicant for the certificate who is aggrieved by an order to deny such certificate; or

(c) More than one-third of the members of the area wide comprehensive health planning agency if the decision of the department is contrary to the recommendation of the area wide comprehensive health planning agency.

(2) Not more than fifteen days after the filing of a notice of appeal, the state board of health shall set a time (which time shall not be more than forty-five days after the filing of notice

of appeal) and place for a public hearing on the application. Every hearing shall be conducted in conformity with the provisions of article 16 of chapter 3, C.R.S. 1963.

(3) The decision of the state board of health on such appeal shall be final, subject to the provisions of section 3-16-5, C.R.S. 1963.

66-38-9. Expiration ~~of certificate - extensions -~~ grievances. (1) A certificate of public necessity shall expire if the construction or modification is not commenced within twelve months following the issuance of the certificate; except that the department may grant an extension of a certificate if good cause is shown why the proposed construction or modification has not commenced.

(2) (a) A hospital or health facility which holds a valid certificate of public necessity issued under this article desiring an extension of such certificate shall file an application for an extension with the area wide comprehensive health planning agency to which it originally made application at least three months prior to the expiration of the certificate; except that an application for an extension of a certificate may be filed less than three months prior to expiration if the proposed construction or modification cannot be commenced due to an emergency, including a natural disaster, labor dispute, or other situation beyond the applicant's control.

(b) Upon receipt of an application for extension, the area wide comprehensive health planning agency shall send a copy to the department and to the state comprehensive health planning

office.

(c) Within sixty days after receiving the application for extension, the area wide comprehensive health planning agency shall recommend that the department either grant or refuse to grant an extension of the certificate. If the recommendation is to grant the extension, the area wide comprehensive health planning agency shall also recommend the length of such extension. Failure of the area wide comprehensive health planning agency to act within the required time shall be deemed a recommendation to grant an extension.

(3) (a) Within thirty days after receiving the recommendation of the area wide health planning agency, the department shall review the recommendation and make one of the following decisions:

(b) Grant an extension of the certificate for an additional specified time period of up to twelve months; or

(c) Deny an extension of the certificate.

(4) (a) A decision of the department to issue or deny an application for an extension of a certificate of public necessity may be appealed to the state board of health within thirty days after receipt of notice of such decision either by:

(b) The applicant for the extension who is aggrieved by an order to deny the extension; or

(c) More than one-third of the members of the area wide comprehensive health planning agency if the decision of the department is contrary to the recommendation of the area wide comprehensive health planning agency.

(5) Not more than fifteen days after the filing of a notice of appeal, the state board of health shall set a time (which time shall not be more than forty-five days after the filing of notice of appeal) and place for a public hearing on the application for extension. Every hearing shall be conducted in conformity with the provisions of article 16 of chapter 3, C.R.S. 1963.

(6) The decision of the state board of health on such appeal shall be final, subject to the provisions of section 3-16-5, C.R.S. 1963.

66-38-10. Development of general principles to govern agencies - factors. (1) (a) The department shall, after consulting with the area wide comprehensive health planning agencies and the state comprehensive health planning agency, develop general principles to govern area wide comprehensive health planning agencies and the department in the performance of their duties concerning review of applications for certificates of public necessity. These principles shall provide for the consideration of the following factors and may provide other guidelines not inconsistent herewith:

(b) The need for health care facilities and services in the area and the requirements of the population of the area;

(c) Maximum and minimum hospital or health care facilities and bed ratios per one thousand inhabitants of the area, subject to differences in requirements of the various designated areas;

(d) The possible economies and improvement in service that may be derived from operation of joint, cooperative, or shared health care resources;

(e) The relationship of the proposed construction or modification to overall plans for the development of the area, including, but not be limited to, such state and area wide plans as have been developed pursuant to section 314 (a) of federal Public Law 89-749, as amended;

(f) The availability and adequacy of the area's existing hospitals and health care facilities currently conforming to state and federal standards;

(g) The benefits to the community from increasing the availability and adequacy of other health services in the area such as outpatient, ambulatory, or home care services which may serve as a possible substitution for inpatient care while at the same time providing high quality health care at a lower cost;

(h) The development of comprehensive services for the community to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area and may include preventive, diagnostic, treatment, and rehabilitation services. Preference shall be given to health facilities which will provide the most comprehensive health services and will include outpatient and other integrated services useful and convenient to the operation of the facility and the community;

(i) The gains that may be anticipated from innovative measures proposed by the applicant for improving the organization and provision of health care.

66-38-11. Department - additional authority - report. (1) In addition to the other duties of the department specifically

set forth in this article, the department shall have maximum flexibility in surveying the health care needs of the state and in recommending a program to reduce or eliminate unnecessary duplication of existing health care services and facilities and to encourage the development of health care facilities and manpower in areas of the state where it determines there is a shortage of such facilities and trained personnel.

(2) In carrying out the purposes of this section to recommend a program to reduce or eliminate areas of duplication and shortage of health care facilities and manpower, the department shall solicit and consider the recommendations of the area wide comprehensive health planning agencies in the areas affected by such duplication or shortage and the state comprehensive health planning agency.

(3) In carrying out its duties under this article, the department is empowered to make such investigations and confer with such persons, groups, and agencies as it deems necessary.

(4) On or before December 1, 1974 and December 1 of each year thereafter, the department shall report to the governor on its activities under this article and shall include in such report an analysis of the effectiveness of this article in achieving the legislative purposes set forth in section 66-38-2 and such recommendations as it may have with respect to any legislative changes that may be necessary or desirable.

66-38-12. Rules and regulations. The department, after consulting with the state comprehensive health planning agency and the area wide comprehensive health planning agencies, shall

adopt rules and regulations necessary to implement this article. Such regulations shall be promulgated and published according to the requirements of section 3-16-2, C.R.S. 1963.

66-38-13. Injunction. The department may seek to enjoin the construction or modification of a hospital or health facility for which a certificate of public necessity has not been issued as required by this article.

66-38-14. Withholding of license and funds - when. The department shall not license or allocate any funds to a newly constructed hospital or health facility or to a hospital or health facility that has modified its facilities if a certificate of public necessity has not been first obtained as required by this article.

66-38-15. Violation - penalty. Any person who constructs or modifies a hospital or health facility without first having obtained a certificate of public necessity, as required by this article, shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine not to exceed five hundred dollars.

SECTION 2. Appropriation. There is hereby appropriated out of any moneys in the state treasury not otherwise appropriated, to the department of health, for the fiscal year ending June 30, 1974, the sum of $_____, or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. Effective date. This act shall take effect January 1, 1974.

SECTION 4. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

BILL B

A BILL FOR AN ACT

CONCERNING HEALTH EDUCATION PROGRAMS IN COLORADO SCHOOLS, AND MAKING AN APPROPRIATION THEREFOR.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Chapter 123, Colorado Revised Statutes 1963, as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 44

HEALTH EDUCATION PROGRAMS

123-44-1. Legislative declaration. The general assembly finds and declares that health education is one of the most neglected and poorly taught subjects in schools today. The school system is the only place where enough children and parents can be reached with enough health facts to have any impact on the level of health in Colorado. It is further declared that many of the serious health problems in Colorado are directly attributable to the poor and inadequate health education of the general public and their incomplete knowledge of health facts. Therefore, it is necessary that more effort and money be expended on education and prevention as a positive approach to good health for all Colorado citizens.

123-44-2. Definitions. (1) As used in this article, unless the context otherwise requires:

(2) "Advisory council" means the school health advisory council.

(3) "Department" means the department of education.

(4) "Health" means the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

(5) "Health education" means a process of growth in an individual by means of which he alters his behavior or changes his attitude positively toward health practices.

(6) "School health education programs" means a unified sequential school health program which may include, but is not limited to, instruction appropriate for various levels of pupil maturity in growth and development; family living; personal health practices; mood and behavior modifying substances; nutrition; selection of food and eating patterns; evaluation and use of health products, information, and services; health careers; dental health; community health; environmental health and ecology; mental health; accident prevention; control of communicable and chronic diseases; and other handicapping conditions.

123-44-3. Advisory council created. (1) The state board of education shall appoint a school health advisory council which shall consist of fifteen members. The members shall serve for three-year terms; except that of the members appointed to take office on July 1, 1973, five shall be appointed for one-year terms, five shall be appointed for two-year terms, and five shall be appointed for three-year terms. Vacancies shall be filled by

appointment by the state board of education for the unexpired term.

(2) The advisory council shall elect a chairman and vice-chairman from among its members. The commissioner of education shall designate appropriate department staff to the advisory council, and the advisory council shall utilize this staff to assist it in performing its duties under this article. Members of the advisory council shall serve without compensation, but the members not compensated by a state agency shall be entitled to their actual and necessary expenses incurred in the performance of their duties. A majority of the members of the advisory council shall constitute a quorum for the transaction of business. The advisory council may request that other agencies and departments of the state government assist it in its deliberations.

(3) The advisory council shall advise the department in the formulation of guidelines and rules and regulations pertaining to school health education programs.

(4) The advisory council shall review applications made under section 123-44-4 for school health education programs and shall recommend priorities for the allocation of available funds.

(5) The advisory council shall advise the department in regard to the duties of the department as specified in section 123-44-6.

123-44-4. Grants. (1) The department may make grants to local school districts and boards of cooperative services from funds appropriated by the general assembly for the purposes of

this article, or from funds available from any other governmental or private source, for school health education programs which it approves after consideration of the factors specified in section 123-44-5.

(2) Application for grants shall be made to the department on forms furnished by the department and shall contain such information as the department may require.

(3) At least six percent of the amount distributed to the school districts and boards of cooperative services under subsection (1) of this section shall be used for program evaluation.

123-44-5. School district health education programs - considerations. (1) (a) In evaluating any school district health education program, the department shall take into consideration all of the following factors:

(b) The local and areawide resources available to meet the objectives of the program;

(c) The range and scope of the health problem areas in the proposal;

(d) The integration of the program and the participation of other public and nongovernment agencies, organizations, institutions, and individuals and their services and facilities, if any, that are available to assist the program. Wherever possible, the department shall give priority to those school health education programs which provide a comprehensive range of health programs and evidence a high degree of community support, either financial or in the furnishing of services and facilities,

or both;

(e) Such other information that the department deems necessary.

123-44-6. Duties of the department. (1) (a) In order to aid and further assist school districts and boards of cooperative services in the expansion of school health education programs, the department shall:

(b) Develop requirements for the certification of health education teachers;

(c) Coordinate the development of in-service health training for teachers which would be acceptable in meeting the certification requirements of the department;

(d) Provide consultative services to local school disticts and boards of cooperative services in the planning, management, and evaluation of school health education programs;

(e) Encourage local school districts to improve the quality and utilization of health educational resources and facilities;

(f) Coordinate development and updating of health curricula guidelines for use by the public schools in developing and expanding their school health education programs;

(g) Coordinate the development of a resource library of materials concerning school health education problems, and make the library available to the school districts of the state;

(h) Cooperate and consult with existing health and medical agencies in the formation of guidelines for school health education programs.

123-44-7. Rules and regulations. (1) (a) The department

may promulgate rules and regulations governing the provisions of this article. Such rules and regulations may include, but need not be limited to:

(b) The requirements to be met in the operation of a school health education program, including record keeping and data compilation;

(c) The conditions that may be imposed on a school health education program to maintain its eligibility for a grant under section 123-44-4.

SECTION 2. Appropriation. There is hereby appropriated, out of any moneys not otherwise appropriated, to the department of education, the sum of _____ dollars ($), or so much thereof as may be necessary, for the fiscal year beginning July 1, 1973, for the administration and implementation of this act.

SECTION 3. Repeal. 123-21-10, Colorado Revised Statutes 1963, is repealed.

SECTION 4. Effective date. This act shall take effect July 1, 1973.

SECTION 5. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.