STAFF EVALUATION

Texas Health Facilities Commission

A Staff Report
to the
Sunset Advisory Commission

1984

TEXAS HEALTH FACILITIES COMMISSION

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SUMMARY

The Texas Health Facilities Commission, created in 1975, is currently active. The agency was established to meet the requirements of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) and to ensure that needed health-care services are made available to Texas citizens in an orderly, economical manner. The primary responsibility of the agency is to determine the necessity for particular health-care projects through the review of and hearings on certificate of need applications.

The need for the commission's function was analyzed and the review found three indicators of a continuing need for state involvement in this area. First, the federal government can impose sanctions on a state that does not have a certificate of need program in compliance with federal regulations. The penalty for non-compliance is the withholding of federal Public Health Extramural Awards (Title XV of the Public Health Service Act) which totaled approximately $250.8 million in Texas in fiscal year 1983. The second indicator of need is that amendments to the Social Security Act in 1983 require states to have in place by October 1, 1986, a "Section 1122" capital expenditure review program unless Congress acts before that date to include capital-related costs in a prospective reimbursement system. The Department of Health and Human Services has proposed rules to "dovetail" the requirements for certificate of need and 1122 review. If the Texas Health Facilities Commission was abolished, a similar structure would need to be developed by the state by October 1, 1986, or hospitals would not be eligible for medicare reimbursement of their capital expenditures. Finally, the commission provides a mechanism to ensure that unnecessary duplications of services and facilities are avoided, that the health-care requirements of a particular area are considered before specific projects are developed or offered, and that the state can specify how, when, and where public funds and resources are utilized for new health-care services and facilities. From June of 1975 until the end of the first half of fiscal year 1984, the agency had received 7,878 applications for projects costing approximately $8.6 billion. Nineteen percent of this total, or $1.6 billion in proposed project costs, have been denied, withdrawn, or partially reduced as a result of the certificate of need process. This is an important indicator of the need for the process since a significant portion of the costs of health-care facilities and services are borne either directly or indirectly by the

public through tax-supported reimbursement systems such as medicare and medicaid.

In regard to the current operations of the agency, the review determined that while the agency is generally operated in an efficient and effective manner, there are nine changes which should be made if the legislature decides to continue the agency. An analysis of alternatives to the current organizational structure and operations of the agency revealed that three other changes could result in substantial benefits. Four issues were also identified that could offer potential benefits but would require major changes in current state policy and could involve potential disadvantages. The following outline describes the changes which should be made if the agency is continued and discusses possible alternatives and additional policy issues.

Approaches for Sunset Commission Consideration

I. MAINTAIN THE COMMISSION WITH MODIFICATIONS

A. Policy-making Structure

1. The statute should be amended to more accurately reflect the responsibilities of the chair as executive director of the agency.

The administration of agency funds and the determination of personnel policies are usually considered managerial in nature and, therefore, the duty of an executive director. Statutorily these are the responsibilities of the three commissioners at the Texas Health Facilities Commission, but are actually handled by the chair who is also the executive director. This is an appropriate delineation of responsibilities and the statute should be amended to reflect this.

2. The statute should specify when the governor shall designate the chair and vice-chair of the commission.

The statute mandates the governor to biennially designate a chair and vice-chair, but does not specify when this should occur. To facilitate the transition between incoming and outgoing chairs and vice-chairs, the statute should be amended to require that the designation occur on September 1 of odd numbered years.

3. The statute should be amended to provide for an acting chair in the absence of the chair and vice-chair.

The statute authorizes the vice-chair to assume the chair's duties in that person's absence, but makes no provision for these responsibilities when both are absent. To ensure the efficient ongoing operations of the agency at those times, these duties should be delegated to the third member of the commission.

B. Overall Administration

1. **The statute should be amended to change the maximum C.O.N application fee to one percent of the total project cost or $15,000, whichever is less.**

The current fee structure is not equitable in that it places a heavier burden on certificate of need applications with a project cost of $2.1 million or less than it does on applications for projects in excess of this amount. The recommended change would correct this inequity, allow the agency to continue to deposit to the general revenue fund an amount greater than their appropriation, and allow future growth in the agency without reducing the current level of funds going into general revenue.

2. **The statute should be amended to more accurately reflect the relationship between the commission and the Texas Department of Health.**

The link between health planning and the regulation of the development of health-care facilities and services requires coordination between the THFC and the TDH. However, since the commission has always functioned independently, the current statutory administrative attachment between the two agencies should be deleted.

C. Evaluation of Programs

1. **The statute should require the commission to determine by September, 1986, if the federal approach of reviewing only new services which involve a capital expenditure or anticipate an annual operating cost above $297,500 is less restrictive than the current approach. If so, the commission should amend their rules accordingly.**

The federal statute requires a certificate of need prior to a health facility offering a new service if any capital expenditure is required or if the service will result in an operating cost above $297,500 per year.

One of these options may be less restrictive than the current state requirement. The commission should explore the ramifications and adjust their rules accordingly, if one of the federal options is reasonable and less restrictive than the current system.

2. **The statute should be amended to authorize the commission to adjust their rules to comply with any changes in the federal law.**

The Texas Health Planning and Development Act was written to reflect the certificate of need requirements in federal law. However, if these requirements change, there are only limited areas where the commission can make adjustments necessary to maintain compliance with the federal regulations. The statute should be amended to prevent a potential situation of non-compliance.

3. **The statute should authorize the commission to establish a technical advisory committee.**

The regulation of the development of health-care services and facilities involves many complex issues. The commission's staffing pattern does not provide enough positions to obtain the expertise needed to understand all of these issues. A technical advisory committee appears to be a cost-effective method of obtaining the expertise needed to make more informed decisions on C.O.N. applications.

4. **The statute should be amended to provide mechanisms to improve the timeliness and usefulness of health facility data for the commission and the Department of Health.**

The statute specifies that the Texas Department of Health shall adopt rules regarding the collection and dissemination of data needed for proper and effective health planning and resource development, after consultation with the Texas Health Facilities Commission. The THFC needs to receive this data in a timely and complete fashion for use in the certificate of need process. However, no formal agreement as to the coordination of the two agencies in this area has been formulated since June of 1978. Therefore, the statute should require the two agencies to develop a memorandum of understanding which clearly defines procedures for the collection of data needed for health planning and regulation. Also, to facilitate the TDH in obtaining the data, the

statute should require the THFC to develop rules which prohibit the acceptance of any applications or participation as a party in a hearing unless the applicant or party have filed the proper data required by the TDH.

II. ALTERNATIVES

1. The statute could be amended to provide for a less restrictive regulatory system that would not jeopardize federal funding.

Concern has been expressed in previous legislative sessions that the current C.O.N. process is too restrictive. However, the legislature has not taken any action which would place the state in non-compliance with federal law as this would potentially jeopardize the public health funds that Texas receives. Statutory changes could be made to provide for a less restrictive approach and to authorize the commission to make necessary adjustments in this approach if failure to do so would result in a reduction of these funds.

2. The statute could require agency staff to become a party in all contested cases of $4 million or more, and to allow their participation in any hearing, if the commission so desired.

In fiscal year 1983, the agency held hearings on proposed facilities and services totaling $1.1 billion in project costs. The inclusion in the case record of a viewpoint, other than the applicant's and those opposing the application, would assist the commission in making fair decisions. This viewpoint could be obtained by a requirement that the staff be a party in major contested cases and in other cases if the commission felt there was a need.

3. The statute could be amended and the rules modified to provide for a staff level executive director and an equalization of the commissioners' responsibilities.

Currently the statute names the chair as the chief executive and administrative officer of the commission with certain designated responsibilities. Through the rule-making process, the chair has numerous other duties which, in many other state agencies, are delegated to the staff or handled by an entire commission. A similar

separation of policy-making responsibilities and administrative duties could be applied to the Texas Health Facilities Commission.

III. OTHER POLICY CONSIDERATIONS

1. Should a post-employment restriction be added to the Texas Health Facilities Commission?

The Public Utility Commission statute has a two year post-employment restriction which prohibits PUC commissioners or employees from obtaining subsequent employment with any utility or business entity which does a significant portion of business with a public utility. It has been suggested that a post-employment restriction be extended to major state regulatory agencies such as the Texas Health Facilities Commission. The restriction would prevent or dissuade the commissioners and staff from being influenced in their decisions by promises of future employment in the health-care industry. However, this type of restriction could cause serious recruitment problems because it limits future job opportunities of agency employees.

2. Should the Public Utility Counsel be authorized to participate in major certificate of need hearings?

The decisions of the commission impact the availability and cost of health care in the state. It may be argued that the current C.O.N. process provides only limited opportunities for consumer input. Expanding the responsibilities of the Office of the Public Utility Counsel would provide a means for the consumer to obtain representation in the hearing process at the Texas Health Facilities Commission. However, it can also be argued that the commission is required to consider the necessity of a proposed project to meet the health-care needs of the people to be served before granting a certificate of need. Proponents to this approach argue that sufficient representation is already provided for consumers and the expansion of the Public Utility Counsel's duties would be an unnecessary burden on taxpayers.

3. Should Texas regulate the development of health-care facilities and services if federal requirements are removed?

The state certificate of need program was established to comply with the federal requirement for such programs and to ensure that health-care services and facilities in Texas are made available, as needed, in

an orderly, economical manner. Critics of the process advocate ending C.O.N. reviews, if federal sanctions for non-compliance are removed, because the process purportedly restricts competition and does not control health-care costs. Advocates of the process argue that the state needs to maintain some control over where and how health-care facilities and services are developed. This is considered important since a significant portion of the costs of health care are paid by the public through tax-supported reimbursement systems, such as medicare and medicaid.

4. Should the certificate of need process be transferred to the Texas Department of Health?

In Texas, the responsibilities for health planning and certificate of need review are located in separate agencies, the Texas Department of Health and the Texas Health Facilities Commission. Thirty-three other states have both functions administered by the state health planning and development agency (SHPDA) located in their state's department of health. Proponents of this organizational structure argue that the combination of the two functions ensures health-care services and facilities are developed in an orderly, economical manner, consistent with the needs identified in the state health plan. In support of the current system, however, it is argued that combining planning and regulation would result in an inherent bias to approve only those applications which validate the state health plan. Deciding each case on its own merit, using the state health plan as a guide, is considered a better means of weighing both the general needs of the state and the particular needs of the community in which a proposed facility would be located.

AGENCY EVALUATION

The review of the current operations of an agency is based on several criteria contained in the Sunset Act. The analysis made under these criteria is intended to give answers to the following basic questions:

1. Does the policy-making structure of the agency fairly reflect the interests served by the agency?
2. Does the agency operate efficiently?
3. Has the agency been effective in meeting its statutory requirements?
4. Do the agency's programs overlap or duplicate programs of other agencies to a degree that presents serious problems?
5. Is the agency carrying out only those programs authorized by the legislature?
6. If the agency is abolished, could the state reasonably expect federal intervention or a substantial loss of federal funds?

BACKGROUND

Organization and Objectives

The Texas Health Facilities Commission was created in 1975 and is currently active. It is composed of three full-time commissioners appointed by the governor, and confirmed by the senate, for staggered six year terms. At least one commissioner, at the time of appointment, must be a resident of a county with a population of less than 50,000; and no person who is actively engaged as a health-care provider or who has any substantial pecuniary interest in a health-care facility can serve as a commissioner. Operations of the commission are carried out by a staff of 29 and an operating budget from state funds of $1,145,846 in fiscal year 1984. The agency's organizational structure and the allocation of funds is depicted in Exhibit I on the following page.

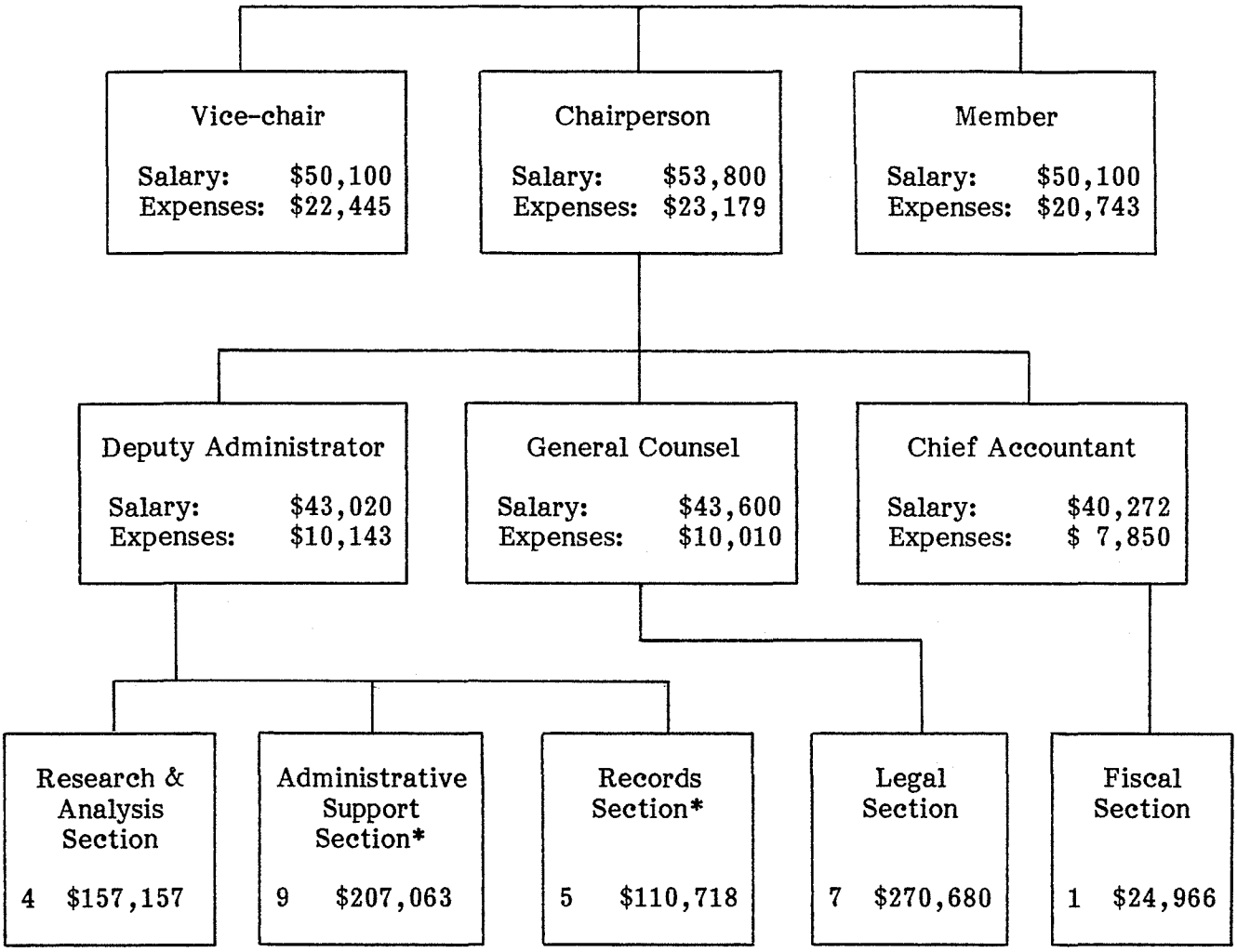
The commission was originally established to meet the requirements of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). This legislation mandated each state to establish a state health planning and development agency (SHPDA), a state health planning advisory council, regional health planning agencies, and a certificate of need program. The need for these programs stemmed from a history of state and federal concern about the availability, accessibility, quality, and cost of health care. The first substantial federal involvement in health planning began in 1946 through the federal Hill-Burton Act, designed to finance the construction of community hospitals in largely underserved areas. This program did much to improve the standards of hospital care and to increase the availability of adequate facilities.

Throughout the 1950's and 1960's the population grew, standards of living rose and medical technology advanced rapidly. The quality of health care improved markedly, but the costs for this care soared. In 1966, the federal government established medicaid and medicare to provide greater access to health care for the poor and elderly, who could no longer obtain these services on their own due to the rising costs. However, this resulted in health-care costs becoming a sizeable and recurring percentage of federal and state budgets. This triggered greater public criticism of the efficiency and effectiveness of the health-care system.

Several attempts were made by the federal government to establish more effective health-care planning. The Comprehensive Health Planning Act of 1966 created a national health planning system, but the program lacked any real

Exhibit I

TEXAS HEALTH FACILITIES COMMISSION
ORGANIZATIONAL CHART AND
DEPARTMENTAL BUDGET ALLOCATIONS



Notes:

1. For the five sections of the agency, the number indicated in the lower left corner of each box represents the number of positions in each section. The number in the lower right corner includes the salaries for these positions plus an allocation of associated expenses such as rent, utilities, supplies, and travel costs.

2. The two sections, designated by an asterisk, provide support services for the entire agency.

authority over the health-care industry and, therefore, was largely ineffective. In 1972, an addition to the Social Security Act (Section 1122) attempted to give the health planning agencies some control over the rising costs of health-care capital investments, but again this authority was limited, and state participation was not mandatory. In 1974, due to continuing concerns over health care, Congress enacted the National Health Planning and Resources Development Act which established the system under which we currently operate. This legislation authorized funding for state and local planning agencies to assess area health needs, set priorities, and attempt to direct health-care resources to the most needed services and locations. It also mandated each state to establish a certificate of need program to determine whether or not a "need" for a proposed facility or service existed, prior to its development.

In response, the 64th Legislature enacted the Texas Health Planning and Development Act (Article 4418h, V.T.C.S.). The Act designates the Texas Department of Health as the state health planning and development agency (SHPDA), with responsibility for developing the state health plan, and establishes the Texas Health Facilities Commission as an independent agency to conduct the state certificate of need program. The purpose of the Act is to "...ensure that health-care services and facilities are made available to all citizens in an orderly and economical manner...", and in compliance with federal requirements. This basic purpose has remained relatively unchanged over the nine years that the commission has operated. However, several modifications have occurred, largely in response to changes at the federal level. For example, in 1979, cost containment was identified as the overriding concern of the federal government relating to health care. The National Health Planning and Development Act was amended by P.L. 96-79 to specifically address the issue of cost containment. All state programs were directed to exempt health maintenance organizations (HMOs) and their activities from virtually all certificate of need review. Facilitating the development of HMOs was seen as a way of enhancing competition by providing the consumer with an alternative to the predominately "fee for service" insurance system, thereby encouraging increased cost-effectiveness overall. The federal government's recent shift to "prospective payment" for medicaid and medicare also has provided hospitals with an incentive to be more cost-effective.

Another change at the federal level occurred in 1981 in regards to the requirement that states review the appropriateness of existing health-care

facilities. The Federal Omnibus Budget Reconciliation Act made provision for states to discontinue this review, so plans to enact appropriateness review in Texas were abandoned in 1982.

In that same year, the president's budget proposed terminating funds for the federal health planning program. However Congress, to date, has not achieved a consensus as to how or even whether health planning should continue. Since 1982, the program has been maintained by a series of continuing resolutions, and funded at $57 million per year. This represents a substantial cut from the $130 million average annual funding between 1976 and 1981. Due to the fact that the Texas Health Facilities Commission has never received any federal funding, this has not had a direct impact on their operations. However, with these decreases in federal funding, the governor opted to discontinue the receipt of local input through the health systems agencies (HSAs) in 1982 and to rely on the SHPDA to perform the local agencies' functions. Consequently, review by the HSAs is no longer required as part of the certificate of need process.

While a number of modifications have been made to the system in order to maintain compliance with the federal guidelines, the responsibilities of the commission still focus on determining if there is a "need" for proposed new health-care facilities and services, prior to their development. The agency also has the authority to investigate alleged violations of the Texas Health Planning and Development Act.

In conducting the sunset review, efforts were focused on a detailed analysis of the certificate of need review process. This approach was taken as all functions within the agency relate to accomplishing this task. A description of the certification process and how it is carried out by the agency follows.

Certificate of Need Program

To meet the requirements of both state and federal statutes, the Texas Health Facilities Commission conducts a certificate of need program. This process is designed to ensure that unnecessary duplications of services and facilities are avoided and that the health-care requirements of a particular service area are considered before specific projects are developed or offered in that area. In fiscal year 1983, 297 applications for certificate of need (C.O.N.) were received, representing $1,144,225,004 in project dollar volume for the year. The average capital cost per C.O.N. application was $3,852,609 in 1983.

Currently, a certificate of need is required prior to the development of a new facility, the offering of a new service, a change in beds of "10 beds or 10 percent", the obligation of a capital expenditure by or on behalf of a health-care facility in excess of $600,000, or the obligation of $400,000 or more for major medical equipment. Hospitals, nursing homes, other types of inpatient facilities, dialysis facilities, and ambulatory surgical centers constitute the primary groups regulated.

Criteria are established both in statute and by agency rule to determine whether there is truly a "need" for a proposed project. These criteria focus on the health-care needs of the community, the economic feasibility of the project, and any special needs addressed by the project such as providing services to indigent patients or to patients in sparsely populated areas. The burden of producing evidence to show that a need exists rests on the applicant.

The certificate of need process is scheduled within a 120 day time frame. This can be extended at any parties' request, if the commission and all other parties agree. The process involves a review by a staff analyst of each C.O.N. application to determine the relationship of the proposed project to the C.O.N. criteria. This analysis is dependent on data obtained primarily from the Texas Department of Health, in regard to existing health services, population figures, and other factors affecting the health-care delivery system in the proposed service area.

A hearing officer reviews the staff analyst's findings and develops a recommendation to the chair, who decides whether a hearing should be conducted or waived. In fiscal year 1983, 144 applications or approximately 40 percent of a total of 364 applications went to hearing. Hearings are conducted pursuant to the Administrative Procedure and Texas Register Act, and are presided over by one of the commission's hearing officers, all of whom are licensed attorneys. Similar projects which are submitted during the same time frame and serve the same area are "joined" and heard together. The hearing provides the applicant with the opportunity to present evidence that the proposed project is "needed", and it provides others with the opportunity to contest applications to which they may be opposed. The hearing officer is responsible for preparing a written recommendation to the commission containing findings of fact, conclusions of law, and a proposed order.

Final discussion and/or arguments are heard by the commissioners at their weekly open meeting. It is at this time that a decision is made by vote of the three

commissioners and an order issued approving or denying an application. Persons who are aggrieved by a commission decision may petition for reconsideration or rehearing. Appeals beyond the commission are made to district court in Travis County.

In fiscal year 1983, the length of time to obtain a decision on a C.O.N. application averaged 87 days if the hearing was waived and 173 days, or less than six months, when a hearing was required. Due to the concern expressed by applicants about the length of time involved in going through the C.O.N. process, the commission proposed rules on May 4, 1984 to streamline the process, especially for uncontested cases.

Other applications which are processed by the commission include: 1) declaratory rulings to determine whether a project falls within the requirements for a C.O.N.; 2) notices of intent for certain projects which are exempt from C.O.N. review; 3) amendments of previously issued commission orders; and 4) petitions for reissuance of a certificate of need. The commission is also authorized by statute to charge an application fee for all proposed projects. Currently, the fee for C.O.N. applications is based on 0.35 percent of the total project cost, with a minimum fee of $250 and a maximum fee of $7,500. The fee for other types of applications (notices of intent, declaratory rulings, etc.) is $100.

Finally, the Texas Health Planning and Development Act provides sanctions for violations of the Act, specifically the development of a project without the commission's authorization. The commission may order a show cause hearing, and if a violation is found, may issue a cease and desist order. In addition, the commission may request the attorney general to institute legal action to enjoin the violation or to recover civil penalties of up to $100 per day for each day of the violation.

REVIEW OF OPERATIONS

The evaluation of the operations of the commission is divided into general areas which deal with: 1) a review and analysis of the policy-making body to determine if it is structured so that it fairly reflects the interests served by the agency; and 2) a review and analysis of the activities of the agency to determine if there are areas where the efficiency and effectiveness can be improved both in terms of the overall administration of the agency and in the operations of specific agency programs.

Policy-making Structure

In general, the structure of a policy-making body should have as basic statutory components, specifications regarding the composition of the body and the qualifications, method of selection, and grounds for removal of the members. These should provide executive and legislative control over the organization of the body and should ensure that members are competent to perform required duties, that the composition represents a proper balance of interests affected by the agency's activities, and that the viability of the body is maintained through an effective selection and removal process.

The Texas Health Facilities Commission (THFC) is composed of three full-time commissioners appointed by the governor, and confirmed by the senate, for staggered six year terms. At least one commissioner must come from a county with a population of less than 50,000 and no one actively engaged as a health-care provider or who has a substantial financial interest in a health-care facility can serve as a commissioner. The governor biennially designates one commissioner to serve as chair and one commissioner to serve as vice-chair. The chair also serves as the chief executive and administrative officer of the commission, and as such, has a wider range of responsibilities and duties than is normally the case for a person who serves as the chair of a commission. All three commissioners are responsible for final case decisions on certificate of need applications.

The review focused on whether the agency's policy-making structure provides an appropriate framework for deciding policy issues in a clearly defined manner. In addition, the rules which govern the policy-making body were examined. Although the operation of the policy-making body appears to be functioning adequately, the following changes should be made to clarify the responsibilities of the chair, to

define the terms of office of the chair and vice-chair, and to provide for an acting chair, in the absence of the chair and vice-chair.

The statute should be amended to more accurately reflect the current responsibilities of the chair as chief executive officer of the commission.

Currently, the responsibilities of the commission, as defined in the Texas Health Planning and Development Act (Article 4418h, V.T.C.S.), include administering the certificate of need program, promulgating and adopting rules, issuing orders on certificates of need and other matters, making an annual report to the governor, administering funds of the agency, and prescribing personnel policies for the agency. These last two duties, relating to administering the funds of the agency and prescribing personnel policies, are areas usually considered as organizational or managerial in nature, and therefore the responsibility of an executive director.

In general, the duties of a board or commission should relate to the setting of major policies for an agency, and not involve the actual administration of the agency. To incorporate this policy into practice at the Texas Health Facilities Commission, it is recommended that the responsibility for administering the agency's funds and prescribing personnel policy be removed from the commission as a whole, and given to the chair of the commission who acts as the chief executive officer. This is a more appropriate delineation of responsibilities and is more in line with the way the agency has actually functioned.

The statute should be amended to specify when the governor designates the chair and vice-chair of the commission.

The Texas Health Planning and Development Act states that the governor shall designate a chair and vice-chair biennially, but does not specify a time frame for when the terms will begin and end. Currently, the commissioners hold office for staggered six year terms, with one term expiring on February 1 of each odd numbered year. It has been the practice for a new commissioner to be appointed to the commission at least six months prior to being designated as the chair in order to gain experience and familiarity with the agency. This is particularly important at the Texas Health Facilities Commission as the chair also serves as the executive director of the agency.

In order for the agency to operate efficiently, the statute should specify when the terms of the chair and vice-chair will begin. To facilitate the transition between chairpersons, it is recommended that the terms begin on September 1 of each odd numbered year, which will coincide with the beginning of the fiscal year and also provide an adequate time period for new commissioners to become familiar with the agency's operations.

The statute should be amended to provide for an acting chair in the absence of the chair and vice-chair.

Currently, provision is made in the statute for the vice-chair to assume the responsibilities of the chair when the chair is absent. In the absence of both, however, a number of necessary functions of the agency can not be performed. These include the acceptance or rejection of applications, waiver of hearings, and scheduling of hearings. When these decisions cannot be made in a timely fashion, the agency may be placed in the position of not being able to maintain the strict time frames specified by rule for final decision on certificate of need applications. While it is rare for both the chair and vice-chair to be absent, if the third member of the commission is available, it appears that this person should have the authority to act on their behalf in order to assure the efficient ongoing operations of the agency. As a member of the commission, this person is appointed by the governor, confirmed by the senate, and entrusted with administering the certificate of need program as prescribed by law. Recognizing that this member is equal to the other commissioners and that the agency needs to have someone who can serve as acting chair, the THFC has proposed a rule that would allow the third member of the commission to assume this responsibility. Since the statute specifically gives this authority to the vice-chair, in the absence of the chair, it would appear appropriate to make a statutory provision regarding the responsibilities of the third member in the absence of both. Therefore, it is recommended that the statute be amended to give the third member of the commission the powers and duties assigned to the chair, in the absence of the chair and vice-chair.

Overall Administration

The evaluation of the overall agency administration focused on determining whether the administrative structure, the management policies and procedures, and the monitoring of management practices were adequate and appropriate for the internal management of time, personnel and funds. The review also examined

whether the Texas Health Facilities Commission had satisfied all applicable state reporting requirements. The results of the evaluation indicated that the agency's administrative operations generally function in an efficient manner. However, the review did identify two areas of concern.

The agency's fee structure should be modified to provide for a more equitable system.

Currently the agency has statutory authority to collect application fees. The maximum amount set in statute is $7,500 or two percent of the total project cost, whichever is less, and the minimum fee is $25. Within those limits, the commission is authorized to establish by rule an appropriate schedule of fees "with the fees for the more substantial projects set at nearer the maximum and fees for the smaller projects set at nearer the minimum" (Article 4418h, Sec. 3.05, V.T.C.S.). The current commission rule regarding certificate of need application fees requires a minimum fee of $250 and a maximum fee of $7,500 or 0.35 of one percent of the total project cost, whichever is less.

As a general principal, the costs associated with regulating an industry should be borne primarily by the regulated group. However, the fees need to be set at a level that offsets the cost of agency operations without unduly burdening smaller applicants and, thereby, limiting their entry into the industry.

The fee schedule developed by the Texas Health Facilities Commission has consistently resulted in deposits to the general revenue fund that exceed the agency's annual appropriation. In fiscal year 1983, approximately $1.4 million in certificate of need application fees were deposited to general revenue. This exceeded the agency's appropriation by approximately $325,674. This system places a heavier burden on smaller applicants than on larger applicants. The average project cost for the certificate of need applications submitted in fiscal year 1983 was approximately $4 million, yet the $7,500 "cap" on fees is reached by projects costing approximately $2.1 million. This means that these smaller projects are paying the same fee as the very largest projects. Although there is not a perfect correlation between the cost of processing a certificate of need application and the project cost, generally the larger projects require more staff time since they are more likely to be protested and go to hearing.

Therefore, the certificate of need fees should be adjusted to provide for a more equitable system. A maximum fee of 0.25 of one percent of the total project cost or $15,000, whichever is less, would provide for a more equitable approach.

This would mean that the "cap" would not be reached until project costs reached $6 million. The fees generated under this system would also allow the smaller projects, which usually require less staff time, to pay less, while allowing the agency to continue to deposit to the general revenue fund an amount greater than their annual appropriation. The increase in this amount also would allow future growth in the agency without reducing the current level of funds going into general revenue. To achieve this, the statute should be amended to allow for a maximum application fee of one percent of the project cost or $15,000, whichever is less. In addition, the commission should amend its rule to limit the maximum fee to the lesser of 0.25 of one percent of the project cost or $15,000.

The statute should be modified to more accurately reflect the relationship between the Texas Health Facilities Commission and the Texas Department of Health.

The Texas Health Planning and Development Act established the Texas Health Facilities Commission and administratively attached it to the Texas Department of Health. The Act also requires that, at the request of the commission, the TDH will provide administrative assistance to the THFC and submit the commission's budget to the legislature. When this Act was originally written in 1975, it was in response to federal legislation which mandated the states establish a state health planning and development agency (SHPDA) to conduct health planning and certificate of need review. Texas designated the Texas Department of Health as the SHPDA, but opted to create a separate state agency to conduct C.O.N. review. As Texas was the first state to separate planning and regulation, the state took precautions in the original statute to provide assurance that the newly created regulatory agency would have any administrative support it needed from the state health planning and development agency. Language included in the Texas statute states that the THFC is "administratively attached to the Texas Department of Health" (Article 4418h, Sec. 2.01, V.T.C.S.), as the state's designated SHPDA.

However, the Texas Health Facilities Commission has functioned as an independent agency since its creation in 1975. The agency has consistently managed all of its administrative responsibilities and budget requests for over eight years, without assistance from the SHPDA. While coordination between the THFC and the TDH is essential, it appears that it is no longer necessary for the two

agencies to be "administratively attached". It is recommended that the Texas Health Planning and Development Act be amended to delete the references which administratively attach the THFC and the TDH, but retain the language requiring the two agencies to coordinate responsibilities in order to avoid unnecessary duplication of facilities and services.

Evaluation of Programs

The major function of the Texas Health Facilities Commission centers on their rulings on certificate of need applications. Accordingly, the primary responsibilities of the staff focus on some aspect of this activity. The following material describes concerns about the certification process which were identified during the review and recommendations for their improvement.

A determination should be made if a less restrictive form of regulating new services exists within the federal guidelines.

The federal statute requires a certificate of need prior to the development of a project which involves any of the following: 1) the offering of a new service; 2) the addition, deletion, redistribution or relocation of more than 10 beds or 10 percent of the facility's total bed capacity, whichever is less, within a two year period; 3) the termination of an existing service if it involves any capital expenditure; 4) the obligation of a capital expenditure in excess of $600,000 by or on behalf of a health-care facility; 5) the obligation of a capital expenditure in excess of $400,000 for medical equipment to be placed in a health-care facility and/or used on inpatients; or 6) the acquisition of an existing facility if the beds or services will be changed. The Texas Health Planning and Development Act (Article 4418h, V.T.C.S.) closely mirrors these requirements. The only variation exists in the regulation of a new service.

Existing federal regulations require a certificate of need prior to the addition of a health service by or on behalf of a health-care facility if there will be a capital expenditure in any amount, or if the new service will have an annual operating cost of $297,500 or more. In Texas, a certificate of need is required prior to the offering of any new service, as defined in the agency's rules, regardless of whether there is a capital expenditure or an expected operating cost. The agency's definition is a broad list of medical services or services that are medically related to the care of a patient. It does not include auxiliary services, such as food

or laundry services, which can involve large capital expenditures or high operating costs.

Since the general approach to state regulation of any activity is that it should be as limited as possible while protecting the public interest, an effort was made to determine if the adoption of one of the federal approaches to the review of new services would be beneficial in Texas. The evaluation included separate consideration of the current requirements for the review of new services in Texas, as well as the two alternative approaches offered by federal law. As previously mentioned, the requirement for a C.O.N. for a new service in Texas is based on the agency's definition in their rules of a "service". If a particular service is not listed in this definition, then a facility does not need a certificate of need to add the service. The federal definition for a new service includes any service which was not offered by or on behalf of a health-care facility within the previous twelve months. Within this broader definition, only those which involve a capital expenditure or anticipate an annual operating cost of $297,500 or more require a certificate of need.

To determine if the federal approach of reviewing a new service if it involves a capital expenditure is less restrictive than the approach used by the agency, certificate of need applications submitted to the Texas Health Facilities Commission during fiscal year 1983 were analyzed. The analysis indicated that 25 of 297 applications, or 8.42 percent, of the total number submitted, would not have required review if this approach had been used. Although fewer applications would have been submitted, the agency indicated that the internal impact of deleting these applications from their caseload would have been minimal, in that most did not require a hearing.

The second federal option requires a certificate of need to provide a new service if that service will have an annual operating cost of $297,500 or more. This approach appears to be less restrictive than the current practice but specific data could not be developed by the agency during the review concerning the number of applications that would not have been submitted if such an approach had been in place during fiscal year 1983. The agency does obtain operating cost information for those services which are involved in a particular project under review. However, since this operating cost information is provided only in the applicant's economic feasibility statement and is not included in those items which are within the commission's legal jurisdiction, it does not appear in the orders issued by the commission. Such information is thus not readily retrievable using the agency's

existing resources. In addition, the agency is not aware of any state governmental bodies which have a pool of health-care facility operating cost information from which a statistical analysis could be drawn.

Both federal approaches appear to have merit, yet there is some concern that neither approach is as fair as the current system. The federal approaches appear to be less restrictive because coverage is limited by requiring review of new services only if a capital expenditure is involved or if the anticipated annual operating cost is $297,500 or more. However, certain services not currently listed in THFC's definition of services would require a C.O.N. under either federal approach. For example, to add a laundry service currently does not require C.O.N. review. Under the first federal approach, a certificate of need would be required because the establishment of a laundry service would involve a capital expenditure. Under the second federal approach, a C.O.N. would be required also if the anticipated annual operating cost would be $297,500 or more.

Since the decision to maintain the current system or adopt either of the federal approaches requires specific information that was not accessible during the review, it appears that the agency should be directed to examine the implications of adopting one of these potentially less restrictive alternatives. Specifically, the agency should be directed by statute to examine the reasonableness of the current system and the federal alternatives. By September of 1986, the Texas Health Facilities Commission should determine which of the options is less restrictive and in keeping with the agency's general mandates. If one of the federal approaches for reviewing new services is found to be less restrictive and reasonably protective of the public interest, the agency should amend its rules to adopt the new approach.

Compliance with federal requirements should be assured by requiring the agency to automatically implement any changes made on the federal level.

Currently the Texas Health Planning and Development Act reflects the certificate of need requirements in federal law. The Act contains four provisions that would allow adjustments on the state level if changes occurred on the federal level. These four are related to the definition of "expenditure minimum" and the requirement for a C.O.N. prior to acquiring major medical equipment, acquiring an

existing health facility, or developing a research-related project. If other changes occurred, the agency would not have the authority to enact them.

This situation has the potential for causing two problems. First, if the federal government deregulated the certificate of need process by exempting more categories from review or simplifying the review criteria, these changes could not be implemented in Texas until action was taken by the legislature. As a result, Texas would be applying a more restrictive regulatory scheme than required by federal law. The second potential problem would occur if the federal government reversed the current move toward deregulation. If federal changes increased regulation, the Texas Health Facilities Commission could not automatically implement changes necessary for the state to remain in compliance. The sanction for non-compliance is the loss of the Public Health Extramural Awards granted by Title XV. These awards amounted to approximately $250.8 million in Texas in fiscal year 1983.

In 1971, the 62nd Legislature authorized the Texas Employment Commission to administer the Unemployment Compensation Act "so as to conform with the provisions of the federal statute(s) until such time as the legislature meets in its next session and has an opportunity to amend this Act" (Article 5521b-22e, V.T.C.S.). To ensure that Texas can maintain compliance with the federal requirements for certificate of need, similar authority should be given to the Texas Health Facilities Commission.

Technical expertise should be made available to the agency through the appointment of an advisory committee.

The regulation of the health-care industry through the certificate of need process is complex. Many factors need to be considered before the commission determines whether there is a need for a particular facility, piece of equipment, or service. Consideration of these factors requires knowledge of the economics of the health-care industry which includes not only understanding the cost reimbursement systems, but also available financing alternatives. In addition, the commission needs current demographic information, as well as current and proposed changes in the licensing and building code standards for hospitals and nursing homes.

The agency's current level of staffing and its composition does not provide the broad based economic health-care expertise which is often needed by the commission to make an informed decision on certificate of need applications. A

generally accepted method of obtaining information from experts is through the establishment of a technical advisory committee. An advisory committee is appropriate when an agency would obtain ongoing benefits from advice and counsel which is not available within the agency. The Air Control Board provides an example of an agency that has benefitted from an advisory committee. Since 1977, this board has utilized a medical resources advisory panel, comprised of physicians and health scientists, to assist in the evaluation of the effects of air contaminants on the public's health.

To provide the Texas Health Facilities Commission with the expertise that is currently unavailable within the agency, the statute should be amended to authorize the commission to establish a technical advisory committee. The composition should include an expert from each profession involved in the development of health-care facilities and services, as well as a representative of the state agencies that regulate these facilities and services after they are developed. The "experts" should include an economist, accountant, engineer, architect, and demographer, all who specialize in the health-care field. In addition, there should be representatives of the health-care industry, the Department of Human Resources, the Texas Department of Health, the Texas Department of Mental Health and Mental Retardation, and the Texas Commission on Alcoholism.

Mechanisms to improve the timeliness and usefulness of health facility data for both the Department of Health and the Health Facilities Commission are needed.

The Texas Health Facilities Commission's review of certificate of need applications is dependent largely upon the availability and accuracy of data regarding the capacity and utilization of existing health-care facilities in the state. This data is collected by the state health planning and development agency (SHPDA) within the Texas Department of Health, after consultation with the THFC, as specified in the Texas Health Planning and Development Act. Articles of agreement relating to the coordination of certain functions between the two agencies were last executed in June of 1978 by the chair of the THFC and the commissioner of the TDH. Since that time a number of changes have occurred which impact the data collection process. The most significant change occurred in 1982 when health systems agencies (HSAs) were discontinued in Texas. Without the

HSAs, there is no longer a system in place for generating information on health-care services at the local level. This and other changes have not been addressed, except at the staff level, since there has been no formal agreement between the two agencies in six years. Consequently, it appears there is no longer a clear understanding of how the THFC and the TDH should coordinate the collection and dissemination of health-care data.

During the review, three areas were examined which related to problems resulting from this lack of coordination. The first was the need for the Texas Health Facilities Commission to have greater access to the data. Currently, the THFC receives the data on computer printouts from the TDH and the staff must collate and analyze, by hand, the data relevant to a particular project. This is an inefficient approach to data analysis. The THFC needs to be able to directly access and manipulate the health-care facility data by use of a terminal located in their offices which will interact with the TDH computer. This currently is not possible because the TDH computer does not have "on-line" capabilities. However, in January of 1985, TDH plans to have operational a new "on-line" system which will allow the THFC to access and manipulate the data directly, thereby resolving this problem.

The second issue examined was whether timely and complete data on existing health-care facilities is available to the commission. The SHPDA annually surveys over 3,000 health-care facilities to determine utilization rates, capacity of the facilities, and services provided by the facilities. Currently, over 90 percent of the facilities in the state respond to the survey, however, many require over nine months in which to do so. This results in an extended time lag in compiling the data, and no information at all from approximately 10 percent of the facilities. While this response rate is acceptable in the planning for overall statewide needs, the Texas Health Facilities Commission needs the data to be complete and as timely as possible in order to make informed decisions on the need for new or expanded facilities and services. Currently, the Texas Health Planning and Development Act states that persons who fail to comply with the rules established for the collection of data pursuant to the Act, are in violation of the Act. However, as clear sanctions for violations of the Act are not specified in statute, the TDH does not have enforcement capabilities. As the THFC requires the data in a more timely and complete fashion, it appears appropriate for the commission to be involved in efforts to improve the current situation. This can be accomplished

through the THFC stipulating by rule that the acceptance of applications and the admission of a party to a hearing are subject to the applicant and parties having filed all the proper health-care facility data with the Texas Department of Health.

The last issue relates to the lack of an update to the formal agreement on the coordination of functions between the two agencies. The current agreement, executed in 1978, includes considerations which are now obsolete. For example, the agreement addresses how the HSAs are to be included in the state certificate of need program. As mentioned earlier, the HSAs were disbanded in December of 1982. In the area of data collection and dissemination, the agreement indicates that the Department of Health will adopt pertinent rules after consultation with the Health Facilities Commission; however, the specific nature of this consultation is not addressed. Since the data collected by the SHPDA is used by the Health Facilities Commission on a routine basis, it is important that the commission be given ample and continuous opportunity to have input into the structure of the TDH data surveys and data collection methods. The interaction between the agencies' staff appears to be frequent and useful; however, certain issues regarding the data collection process remain to be resolved. One recent example of an unresolved issue relates to the methodology adopted by the TDH to develop bed need projections for short-term acute care hospitals and nursing homes. The THFC indicates that the methodology needs to yield projections for the 254 counties of the state. The TDH methodology for the 1985 state health plan will yield projections for the twelve health service areas and the 24 area planning councils (COGS). The basic problem appears to be that TDH is compiling data in order to plan for the health-care needs of the state as a whole, whereas the THFC requires data to evaluate the health-care needs of a specific area where a particular facility or service is being proposed. However, the health department indicates that the current approach is a significant improvement over previous bed need projections and that the agency is not able to obtain sufficient data to make the county level projections desired by THFC.

It is unlikely that this issue can be quickly resolved. However, it is important that a process for continuing dialogue between the agencies be developed to consider these and other issues which will undoubtedly arise in the future. The articles of agreement last developed between the two agencies is a good mechanism for such interaction, but it needs to be revised. Due to the importance of cooperation and interaction between the two agencies it appears that the

articles of agreement should be updated in the form of a "memorandum of understanding" (MOU) which clearly outlines the duties of each agency in the execution of their various functions under the federal and state health planning statutes. To ensure that periodic examinations of the relationships occur and that the needs of each agency are mutually considered, the state health planning act should be amended to require an annual review and update of the MOU. Further, the adoption of the MOU should utilize the rule-making procedures of the Administrative Procedure and Texas Register Act to provide input from interested parties and result in the adoption of the MOU as formal rules of each agency. By following this process, issues such as data collection and dissemination can receive continuous attention and refinement over the coming years.

In summary, it is recommended that the following changes be made in order to improve coordination between the Texas Department of Health and the Texas Health Facilities Commission in the collection and dissemination of health-care data. First, to facilitate the TDH in obtaining data from existing health-care facilities, the statute should require the THFC to develop rules which prohibit the acceptance of applications or the admission of a party to a hearing unless the applicant and parties have filed the health-care facility data required by the Texas Department of Health. Secondly, the statute should require the TDH and the THFC to develop and mutually agree to a memorandum of understanding. This document should clearly define the role of each agency and provide for periodic interaction to resolve such issues as appropriate procedures for the collection and dissemination of data necessary for proper and effective health planning and certificate of need review.

EVALUATION OF OTHER SUNSET CRITERIA

The review of the agency's efforts to comply with overall state policies concerning the manner in which the public is able to participate in the decisions of the agency and whether the agency is fair and impartial in dealing with its employees and the general public is based on criteria contained in the Sunset Act.

The analysis made under these criteria is intended to give answers to the following questions:

1. Does the agency have and use reasonable procedures to inform the public of its activities?
2. Has the agency complied with applicable requirements of both state and federal law concerning equal employment and the rights and privacy of individuals?
3. Has the agency and its officers complied with the regulations regarding conflict of interest?
4. Has the agency complied with the provisions of the Open Meetings and Open Records Act?

EVALUATION OF OTHER SUNSET CRITERIA

The material presented in this section evaluates the agency's efforts to comply with the general state policies developed to ensure: 1) the awareness and understanding necessary to have effective participation by all persons affected by the activities of the agency; and 2) that agency personnel are fair and impartial in their dealings with persons affected by the agency and that the agency deals with its employees in a fair and impartial manner.

Open Meetings/Open Records

The review of the commission's compliance with the Open Meetings Act indicated that the agency has filed timely notices of commission meetings with the Office of the Secretary of State. The agenda is specified in this notice as well as in the weekly mailout sent to the appropriate health-related state agencies and approximately 400 subscribers. In addition, the agency provides written notice to the parties in each certificate of need case of the scheduled open meeting date when the case they are interested in will be considered. Executive sessions held by the commission appear to be properly announced and are used to discuss permissible topics, such as pending litigation and proposed settlement offers, and not pending case matters.

The Texas Health Facilities Commission's records policy is in compliance with the Open Records Act. Employees are instructed to allow inspection of commission records upon receipt of a written request for such inspection. In accordance with the Open Records Act, personnel files, information relating to civil litigation, and drafts and working papers used to prepare potential legislation are the only exceptions to this policy.

EEOC/Privacy

An evaluation was conducted to determine the extent to which the agency has complied with applicable provisions of state and federal statutes relating to equality of employment opportunity and the rights and privacy of individual employees. The agency does not have an affirmative action plan, but the review indicated that this is not required for this agency. The Texas Health Facilities Commission evaluates all employees and prospective employees on their merit and job related criteria without regard to race, color, national origin, religion, sex, age, or handicap. There have not been any charges of discrimination or unfair employment practices filed against the agency with the Equal Employment

Opportunity Commission. The results of the review indicated that the agency performs adequately in this area.

Public Participation

The commission informs the public of its activities through their weekly mailout to subscribers, postings in the Texas Register, preparation of articles for publication in journals or newsletters of health-related associations and state agencies, and public speaking engagements. Public participation in the rule-making process is encouraged in a number of ways. First, pursuant to commission rule, any person may petition the agency to adopt, repeal or amend a rule. Second, any time a rule change is prepared, the commission submits it for publication in the Texas Register according to the Administrative Procedure and Texas Register Act. Third, the agency sends copies of the proposed rule(s), free of charge, to every health-care facility in the state, health-related agencies and associations, and to all subscribers to the commission's weekly mailout. Comments are invited and a public hearing is held for the receipt of written and verbal comments. Once adopted, copies of the rules are sent to the same persons and entities that received the proposed rules. The review indicated that the commission provides the public with appropriate access to general information about the agency's activities, as well as the policies and procedures that govern these activities.

Conflict of Interest

The review indicated that the commission has established adequate procedures for making commission members and employees aware of their responsibilities under conflict of interest statutes. The primary method utilized is to give each commissioner and staff person a copy of the agency's Personnel Manual on the first day of employment. The manual includes a copy of the statutory provisions related to conflict of interest. Employees are informed of the requirement to review and adhere to these statutes. The agency has developed a form for employees to sign indicating they have received a copy of these laws. In addition, the agency's general counsel is responsible for counseling individual commissioners about voting or excusing themselves from voting on cases where a potential conflict exists.

According to state law, appointed state officers are subject to specified standards of conduct (Article 6252-9b,V.A.C.S.). This includes, in certain circumstances, the filing of financial disclosure statements with the Office of the Secretary of State. A review of the documents filed with the Secretary of State indicated that the three commissioners of this agency have filed the appropriate financial statements.

ALTERNATIVES

The analysis of whether there are practical alternatives to either the functions or the organizational structure are based on criteria contained in the Sunset Act.

The analysis of alternatives is directed toward the answers to the following questions:

1. Are there other suitable ways to perform the functions which are less restrictive or which can deliver the same type of service?
2. Are there other practical organizational approaches available through consolidation or reorganization?

ALTERNATIVES

As part of the review of this agency, the functions performed by the agency were evaluated to determine if alternatives to current practices were available. State agencies with functions similar to those performed by this agency were reviewed to determine if they had developed alternative practices which offered substantial benefits and which could be implemented in a practical fashion. In addition, the practices of other states were reviewed in a like fashion to determine if their practices were similar to those of Texas. It was concluded that three practical alternatives to current practices exist, and they are discussed below.

The statute could be amended to provide for a less restrictive regulatory system that would not jeopardize federal funding.

Under state law a certificate of need is required for a proposed project to: 1) obligate a capital expenditure in excess of $600,000; 2) offer a new institutional health-care service; 3) terminate an existing service if it requires any capital expenditure; 4) acquire medical equipment costing more than $400,000, unless exempt pursuant to federal law; 5) change the bed capacity or number of licensed beds by 10 beds or 10 percent of the total number in the facility, whichever is less, in a two year period; or 6) acquire an existing health-care facility, unless exempt pursuant to federal law. In order to avoid the application of sanctions by the federal government, this statutory framework is based on requirements in federal laws and regulations. The penalty for non-compliance with the federal guidelines is the loss of the Public Health Extramural Awards granted by Title XV which totaled approximately $250.8 million in Texas in fiscal year 1983.

In previous legislative sessions, interest has been expressed in deregulating or reducing regulation of the health-care industry. Particular concern has been expressed about: 1) the capital expenditure thresholds; 2) the requirement for a C.O.N. for state-owned and operated health-care facilities and services; and 3) the requirement for filing a notice of intent to acquire an existing health-care facility. The requirement for review of any project involving a $600,000 capital expenditure or a project for acquisition of medical equipment costing more than $400,000 has purportedly caused health-care facilities to go through this process for minor expansion or renovation projects and to acquire replacement equipment. Also, since there are no federal exemptions from review of facility expansions, expendi-

tures, new services, and other projects to be developed by state-owned and operated health-care facilities, a C.O.N. is required any time a new or renovated facility, equipment or service is needed at a state hospital or state school operated by the Texas Department of Mental Health and Mental Retardation. This situation exists even though the "need" for these projects has already been determined and approved through the state legislative appropriations process. Finally, the requirement to file a notice of intent to acquire an existing health-care facility imposes a burden on the applicant, as well as the commission. This notice of intent process, as defined by the federal government, does not yield information that is useful to the commission or in keeping with the agency's goals. The federal regulations require that this notice only address whether there will be a change in services or bed capacity of the facility within one year of the acquisition. Since a certificate of need would be required anyway if the facility was going to add services or substantially change the bed capacity, the current notice of intent process appears to be unnecessary and potentially duplicative.

Although concern has been expressed about the shortcomings of the current system, the legislature has not taken any action which would place the state in non-compliance and potentially jeopardize the public health funds that come into Texas. As a part of the review, other states' certificate of need programs were examined to determine if an acceptable alternative to the current system existed. As with other regulatory processes in the state, the standard for comparison was whether other states' C.O.N. processes would protect the public interest in receiving those federal funds without unreasonably restricting entry into or activity within the health-care industry.

The review indicated that the state of Washington went out of compliance with the federal program in 1983 by changing their expenditure minimum from the federally required $600,000 to "$1 million...or a lesser amount required by federal law and established by the department by rule". Although 28 states are out of compliance with federal standards for various reasons, Washington appears to be the only one that has provided a safeguard against federal sanctions. The advantage to a system like Washington's would be that it would allow Texas to develop a regulatory system tailored to the needs of the state, rather than adhering to a federally imposed system, without jeopardizing federal funds for public health services. The legislature could indicate in the statute the amount they preferred

for the capital expenditure threshold yet authorize the commission to adjust this if federal sanctions were going to be applied.

However, just increasing the expenditure minimum will have only minimal impact on the current system since several requirements for a certificate of need are not tied to a specific capital expenditure threshold. These include the requirements for a C.O.N. to offer any new service, terminate an existing service, change bed capacity, or, unless exempted by federal law, to acquire an existing facility.

To resolve the problems in the current system and provide for a less restrictive regulatory system that would not jeopardize federal funding, three statutory changes could be made. First, the definition of expenditure minimum could be modified to include the obligation of a capital expenditure that exceeds $1 million for: 1) any project by or on behalf of a health-care facility; 2) the acquisition of medical equipment; or 3) the implementation or termination of a service. To protect the state from penalties, this definition could also include authorization for the commission to lower the threshold, by rule, in response to a proposed application of sanctions by the federal government. To provide for flexibility in the future, the commission could be authorized to increase the threshold each biennium by $1 million, up to a maximum of $4 million.

The second change would involve an adjustment in the requirements for a certificate of need or notice of intent. Acquisitions of existing facilities and projects proposed by the Texas Department of Mental Health and Mental Retardation could be exempted from review. Also, the requirement for a C.O.N. for bed changes could be increased to 20 beds or 20 percent of the total number, whichever is less, in a two year period. Finally, to ensure sanctions would not be applied, the commission could be authorized to modify by rule the areas of coverage to comply with the appropriate federal laws and regulations, if failure to do so would result in a reduction of public health funds in the state.

In summary, the following steps could be taken by the legislature to address the major concerns about the current certificate of need process: 1) the expenditure minimum could be increased and applied to capital expenses for health-care facilities, medical equipment, and services; 2) certain projects could be exempted from coverage; and 3) the commission could be authorized to make necessary adjustments if failure to do so would result in a reduction of federal public health

funds in Texas. The combination of these three changes could provide the state with a regulatory system that is less restrictive yet safeguards the public interest.

The statute could be amended to require agency staff to become a party in all contested cases of $4 million and above and to allow their admission, at the commission's discretion, to any case that goes to hearing.

In fiscal year 1983, the Texas Health Facilities Commission held 144 hearings involving certificate of need applications totaling $1.1 billion in project costs. Currently the only commission staff members involved in the hearings on these applications are the hearing officers. This situation does not provide for direct representation of the consumer who is generally unaware how projects can and do effect the cost of health care. It is estimated in reports from the Department of Health and Human Services that for every $100 spent in capital expenditures for a health-care facility or service there is an associated annual operating cost of approximately $30 for every year the facility or service exists. The effect of this on the general public is substantial since they bear a significant portion of the costs of health care through tax-supported cost reimbursement systems such as medicare and medicaid.

Another problem with the current hearing process is that it has limited the information that can be developed in the record in three ways. First, if the case is "joined" or protested, the opposing parties focus on proving their case rather than determining the actual need for a particular facility or service in a specified area. This often results in the presentation of the opposite ends of the spectrum and does not provide an unbiased look at the community's needs. The second reason is that in a hearing that is not protested or "joined", only one viewpoint, that of the applicant, is presented. Finally, the hearing officer often can not get the type of information needed to complete the record through the clarifying examination. To do so would require the hearing officer to assume an adversarial position which is inappropriate for one who should remain objective and unbiased.

This inability to get all needed information into the record has caused two problems. The commissioners have been placed in the position of making a decision without complete evidence or have been forced to order that a hearing be reopened so that specific information can be added to the record.

Many state agencies with an administrative hearing process provide a broader approach to ensuring that all interests are represented and that needed information is obtained by admitting agency staff as a party to an application. For example, in fiscal year 1982, the Public Utility Commission was involved in 183 rate cases involving requests by utilities for increases of approximately $1.6 billion. To ensure that each case record included the information necessary for the public utility commissioners to make a fair and unbiased decision, approximately ninety employees were involved.

A similar approach would appear to be beneficial to the Texas Health Facilities Commission since their decisions effect not only the cost of health care, but the public's access to that care. However, the agency indicates that to adequately analyze the certificate of need applications in preparation for the hearings and to participate as a party in the hearings would require 22 additional staff persons. The total cost is estimated to be $786,860 per year. Although the agency's current fee structure will return to the general revenue fund an amount equal to their appropriation plus approximately $663,495, this would not cover the cost of this new activity.

If the legislature chose to fund this activity, one drawback would be that it would require the use of the money currently being returned to general revenue plus approximately $123,365. In addition, the inclusion of the Texas Health Facilities Commission's staff in the hearings could add to the length and complexity of the hearings, thereby increasing the time required to get a decision on an application. The benefit would be the development of a record that provides for broad representation of the interests of all persons effected by the commission's decision. The inclusion of the staff's independent viewpoint would provide a balance to the commission in making a determination that ensured health-care services and facilities were developed, as needed, in Texas in an orderly and economical manner. Therefore, it appears that the benefits accrued through the participation of the staff in these hearings outweigh the potential drawbacks.

The statute could be amended and the rules modified to provide for a staff level executive director and an equalization of the powers of the commissioners.

The Texas Health Planning and Development Act (Article 4418h, V.T.C.S.) designates the chairperson of the Texas Health Facilities Commission as the chief

executive and administrative officer of the commission. The statutory responsibilities that accompany the role of executive director are limited. However, through the rule-making process, the chair has been given many other responsibilities which, in many state agencies, are delegated to the staff or decided by the entire commission. Some of these duties are minor or require little discretionary judgement since the commission has specific rules to govern them. However, six of the chair's current responsibilities have the potential to have a significant impact on the agency's operations or the regulated industry. These include the suspension of the receipt of applications, the waiver of hearings, the issuance of subpoenas, the authority to reopen a hearing and limit evidence, the initiation of forfeiture proceedings, and the issuance of orders for show cause hearings.

The review identified three concerns with the current system. First, the responsibilities given to the chair in the statute and the agency's rules appear to be excessive for one person. This presents a particular problem at the Texas Health Facilities Commission since the chair is also responsible for reviewing the records and voting on certificate of need applications. However, the current and former chairpersons have handled these responsibilities by delegating much of the work to designated staff. Second, the agency's rules place too much authority in the chairperson by authorizing the chair to make decisions that appear to be better made through consensus rather than independent individual action. One of the major reasons for a multi-member board or commission is that it provides a system that can examine situations from varying viewpoints and arrive at decisions that are fair and balance the needs of the state with the needs of the regulated industry. Finally, the current statute does not allow for separation of the policy-making activities and the daily administration of the agency. In most state agencies, policy-making activities are kept separate from the ongoing operation of the agency by the employment of a staff level executive director.

A change in the statute and rules to provide for a staff level executive director and an equalization of the duties of the three commissioners appears to have several benefits. It would relieve the chairperson of the routine administration of the agency so he could focus on policy decisions and review of certificate of need cases. In addition, it would better disperse substantive decision-making powers currently concentrated in one individual. Finally, it would provide the legislature with access to a high level person in the agency who is not a "decision-maker" and, therefore, not governed by the agency's ex parte rule. This rule

prohibits the commissioners from communicating, directly or indirectly, about any issue of fact or law on a pending application with any agency, person, party, or their representatives except on notice and opportunity for all parties to participate.

Three disadvantages to this change were identified during the review. First, the agency has not identified any problems with the current system and feel that the proposed change to a staff level executive director would cause an internal upheaval in the agency. Also, concern was expressed that rule changes to allow the entire commission to make decisions that are currently made by the chair would result in a less efficient process. Since these decisions would have to be made in an open meeting, the certificate of need process would be lengthened. Finally, the review indicated that the reason that the chair was originally designated as the executive director was to provide the governor and legislature with a single contact who was in charge of the administration of the agency and involved in the decision-making process. A change in the current system would eliminate this access. It appears, however, that the benefits that would accrue from the employment of a staff level executive director and the equalization of the commissioners' duties outweigh the potential drawbacks.

OTHER POLICY CONSIDERATIONS

During the review of an agency under sunset, various issues were identified that involve significant changes in state policy relating to current methods of regulation or service delivery. Most of these issues have been the subject of continuing debate with no clear resolution on either side.

Arguments for and against these issues, as presented by various parties contacted during the review, are briefly summarized. For the purposes of the sunset report, these issues are identified so they can be addressed as a part of the sunset review if the Sunset Commission chooses to do so.

OTHER POLICY CONSIDERATIONS

This section covers that part of the evaluation which identifies major policy issues surrounding the agency under review. For the purpose of this report, major policy issues are given the working definition of being issues, the resolution of which, could involve substantial change in current state policy. Further, a major policy issue is one which has had strong arguments developed, both pro and con, concerning the proposed change. The material in this section structures the major question of state policy raised by the issue and identifies the major elements of the arguments for and against the proposal.

Should a post-employment restriction be added to the Texas Health Facilities Commission's statute?

The Public Utility Commission (PUC) has in its statute a two year post-employment restriction which prohibits PUC commissioners or employees from obtaining subsequent employment with any utility or a business entity which does a significant portion of business with a public utility. On the federal level, former employees of regulatory agencies are prohibited from any involvement with an application they were involved with while working at the agency. It has been suggested that some type of post-employment restriction be extended to major state regulatory agencies such as the Texas Health Facilities Commission.

Agencies with extensive regulatory authority, such as the commission, hear cases having significant financial impact which directly affect the public interest. The limits on future employment would prevent or dissuade agency staff and commissioners from being influenced in their decisions by promises of future employment in the health-care industry. The restrictions would also prevent the commission from being a short-term training ground. Working at the commission provides employees with the opportunity to gain skills and knowledge about the C.O.N. process in general, and about certain cases in particular, which can then be effectively marketed in the private sector.

Opponents of the two year rule state that it is too broad in its application. Major conflicts of interest that may exist could be satisfactorily taken care of through the use of the less restrictive federal approach that would not close future job markets, but would prohibit participation in cases the employee or commissioner was involved with while at the agency.

Arguments against the extension of any post-employment restriction include a theory that it would cause an "exodus" in current professional staff prior to the enactment of the statute. In addition, it is argued that these type of restrictions cause serious recruitment problems. State agencies already have difficulty attracting qualified employees because of salary limitations. If potential employees knew that future job markets were limited by a post-employment restriction, the agency would have even greater difficulty encouraging competent people to enter the public sector.

Should the Public Utility Counsel be authorized to participate in major certificate of need hearings?

Consumers pay for health care in three ways: 1) direct payment for services; 2) the purchase of medical insurance; and 3) the payment of taxes for publicly supported health-care programs such as medicare and medicaid. The cost of health care continues to increase, but the consumer can have only minimal impact on this situation in the marketplace. When a person needs inpatient medical care, there is rarely an opportunity to "shop around". One goes to the hospital selected by one's doctor.

The current certificate of need process allows only limited opportunities for consumer input. There are no longer any health systems agencies providing this input at the regional level. When a C.O.N. application is filed, consumers may become a "party" or "interested person". However, one of the responsibilities of a party is sharing the transcription costs of the hearing. There may be additional costs involved for a party or interested person if the consumer wants legal representation or has to travel to Austin to attend the hearing.

Proponents of the Public Utility Counsel representing the consumer in major C.O.N. cases assert that all persons affected by the commission's decisions need to be adequately represented in the hearing process. While health-care providers recognize this need and have the resources to obtain competent representation, consumers do not. These people often cannot afford to pay for private attorneys, and it can be argued that consumer advocate groups are already overworked and underfunded. Under current law, the agency's legal staff function as administrative law judges and, therefore, can not represent consumers or any other group. They must remain in an objective, non-adversarial position. If authorized to do so, the Public Utility Counsel could monitor the activities of the health-care industry

and obtain information necessary to present an effective case before the commission on behalf of consumers.

In opposition to this type of expansion of the Public Utility Counsel's authority, the argument has been made that there has been no public demand for consumer representation in the certificate of need process. The commission, made up of public members, is required to consider the necessity of a proposed project to meet the health-care needs of the community or population to be served before granting a certificate. Also, many certificate of need applications are contested thereby providing the commission with the opportunity to hear both sides of a case. Allowing consumer representation by the Public Utility Counsel would not provide the commission with additional information on which to make a decision, would require an increase in the counsel's staff, and would be an unnecessary burden on the taxpayer.

Should Texas regulate the development of health-care facilities and services if federal requirements are removed?

The certificate of need process was established in federal law to improve the public's access to health services and to restrict investment in unnecessary services and facilities. Excess investment in construction of and equipment for health-care facilities has been identified as a major cause for the growth in health-care costs. Several factors have contributed to this over investment: 1) the prevalence of the third-party payment system which removes the incentive for consumers to demand cost-effective treatment; 2) the competition between hospitals for doctors by offering them access to the latest technological developments, rather than competing for patients by offering good health care at the lowest possible cost; and 3) the availability of federal subsidies to finance capital investments in the health-care field.

The state certificate of need program was established to comply with the federal requirement that states develop such programs and to ensure that health-care services and facilities are made available to Texas citizens, as needed, in an orderly, economical manner. Critics of the process advocate ending C.O.N. reviews, if federal sanctions for non-compliance are removed, because it purportedly restricts competition and increases hospital cost inflation rather than helping to control health-care costs.

Advocates of the process argue that even if federal requirements end, the state should maintain some control over where and how health-care facilities and

services are developed. It has been noted that with economic trends pointing to a decrease in the reserve of capital available to all Texas industries, particular forethought and planning should be applied to the allocation of capital and other resources needed for such a vital industry as health care. Proponents of this position state that if Texas does not maintain control over the development of health-care facilities and related capital investments, control will be vested entirely in the federal government through its tax-supported reimbursement systems such as medicare and medicaid.

Further arguments for continuing the C.O.N. process include a theory that abolishing the system would encourage hospitals to accelerate their investment plans which would lead to faster growth in hospital costs and higher outlays for medicare and medicaid. Consideration must be given not only to the amount of money involved in capital expenditures for new, remodeled, or expanded facilities, but also to the cost involved in operating a facility or service. According to figures utilized by the Department of Health and Human Services, for every $100 in capital expenditures, there is an associated annual operating cost of approximately $30 for every year the facility or service exists. Since a significant portion of the costs of health care are borne, directly or indirectly, by public tax funds through reimbursement systems such as medicare and medicaid, the certificate of need program provides Texas with the ability to specify how, when, and where such funds are expended.

Opponents of the certificate of need process argue that the system should be abolished because of a lack of evidence that it has restrained growth in hospital investment or costs. It is felt that the potential of the review process to contain costs is offset by the costs imposed by the process on participating facilities.

Those opposing the C.O.N. process further maintain that the "free enterprise" system should be allowed to exist in the delivery of health-care services and the construction of facilities for these services. Laws of the marketplace would determine the appropriate placement of facilities such as hospitals, nursing homes, ambulatory surgery centers, and dialysis facilities. Any planning associated with the provision of health-care services would be made directly by providers.

Should the certificate of need process be transferred to the Texas Department of Health?

The Texas certificate of need program is currently set up in an independent state agency, the Texas Health Facilities Commission, separate from the state

health planning agency which is located within the Texas Department of Health. However, thirty-three other states have their C.O.N. program administered by the state health planning and development agency (SHPDA), located in their state's health department.

Proponents of combining health planning and regulation within the Department of Health contend that it is the best way to assure the coordination of the two functions in accomplishing the state's overall goal of ensuring that health-care services and facilities are made available to Texas citizens in an orderly, economical manner, consistent with the needs of the various areas and populations of the state. With the two functions operating together, the regulatory aspect would assure that only projects which meet the health-care needs of the state, as identified in the state health plan, were approved. It is argued that currently C.O.N. applications are too often decided in isolation, by examining only the needs of the immediate area involved, without consideration of the overall needs of the state. Furthermore, if the responsibility for conducting C.O.N. review was placed within the Department of Health, overall administrative costs would be reduced by the elimination of an independent state agency to conduct C.O.N. review.

Proponents of maintaining the current structure argue that if health planning and regulation were combined, there would be an inherent bias to approve applications which validate the state health plan. This would place an inordinate amount of weight in C.O.N. reviews on what the state health plan recommends. In a state as large and varied as Texas, it is difficult for the state plan to accurately represent the changing health-care needs of so many different areas and communities. It is argued that a more equitable approach is to decide each case on its own merit, using the state health plan as a guide, but balancing the overall needs of the state with the particular needs of the community in which the facility would be located. This is a less restrictive approach, which can adapt to the changing needs in the state for health-care services. In addition, it is particularly important to consider the length of time required to obtain a final decision on certificate of need applications. It is contended that moving the process from a small, independent agency whose primary function is to conduct C.O.N. review to a large, multi-layered decision-making agency, such as the Texas Department of Health, would only lengthen the process. This would result in increased costs to the applicants, which eventually would mean added costs to the consumer.

ACROSS-THE-BOARD RECOMMENDATIONS

From its inception, the Sunset Commission identified common agency problems. These problems have been addressed through standard statutory provisions incorporated into the legislation developed for agencies undergoing sunset review. Since these provisions are routinely applied to all agencies under review, the specific language is not repeated throughout the reports. The application to this agency is denoted in abbreviated chart form.

TEXAS HEALTH FACILITIES COMMISSION

Applied	Modified	Not Applied	Across-the-Board Recommendations
			A. GENERAL
X			1. Require public membership on boards and commissions.
X			2. Require specific provisions relating to conflicts of interest.
X			3. Provide that a person registered as a lobbyist under Article 6252-9c, V.A.C.S., may not act as general counsel to the board or serve as a member of the board.
X			4. Require that appointment to the board shall be made without regard to race, color, handicap, sex, religion, age, or national origin of the appointee.
	X		5. Specify grounds for removal of a board member.
X			6. Require the board to make annual written reports to the governor, the auditor, and the legislature accounting for all receipts and disbursements made under its statute.
X			7. Require the board to establish skill-oriented career ladders.
X			8. Require a system of merit pay based on documented employee performance.
X			9. Provide that the state auditor shall audit the financial transactions of the board at least once during each biennium.
	X		10. Provide for notification and information to the public concerning board activities.
*			11. Place agency funds in the Treasury to ensure legislative review of agency expenditures through the appropriation process.
X			12. Require files to be maintained on complaints.
X			13. Require that all parties to formal complaints be periodically informed in writing as to the status of the complaint.
		X	14. (a) Authorize agencies to set fees.
X			(b) Authorize agencies to set fees up to a certain limit.
X			15. Require development of an E.E.O. policy.
X			16. Require the agency to provide information on standards of conduct to board members and employees.
X			17. Provide for public testimony at agency meetings.
X			18. Require that the policy body of an agency develop and implement policies which clearly separate board and staff functions.

*Already in statute or required.

Texas Health Facilities Commission
(Continued)

Applied	Modified	Not Applied	Across-the-Board Recommendations
			B. LICENSING
		X	1. Require standard time frames for licensees who are delinquent in renewal of licenses.
		X	2. Provide for notice to a person taking an examination of the results of the exam within a reasonable time of the testing date.
		X	3. Provide an analysis, on request, to individuals failing the examination.
		X	4. Require licensing disqualifications to be: 1) easily determined, and 2) currently existing conditions.
		X	5. (a) Provide for licensing by endorsement rather than reciprocity.
		X	(b) Provide for licensing by reciprocity rather than endorsement.
		X	6. Authorize the staggered renewal of licenses.
*			7. Authorize agencies to use a full range of penalties.
*			8. Specify board hearing requirements.
		X	9. Revise restrictive rules or statutes to allow advertising and competitive bidding practices which are not deceptive or misleading.
		X	10. Authorize the board to adopt a system of voluntary continuing education.

*Already in statute or required.