



MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

TO : Assistant Secretary for Health
and Scientific Affairs

DATE:

Attention: Deputy Assistant Secretary
for Policy Development

FROM : Administrator, HS

SUBJECT: RMP Issue Paper (October 19th) and the Secretary's Decision
on RMP and Health Revenue Sharing

The RMP issue document is a conscientious effort to analyze the future direction of the program. However, in light of the Secretary's recent decision to incorporate RMP into special health revenue sharing, we believe that the issue document should be revised in such a way as to constitute an appeal to the Secretary's decision regarding RMP and special health revenue sharing.

This could be accomplished by revising the introduction to the issue paper to make it clear that the paper constitutes an appeal to the Secretary's revenue sharing decision. I would also suggest that the introductory statement include much of the substance of my August 10 memorandum to you concerning RMP as a provider constituency.

The organization of the material in the remainder of the issue document creates the erroneous impression that these issues exist side by side so that decisions can be made on one issue without adversely affecting the range of options that are available on subsequent issues. Obviously, this circumstance is not the case. The issues are related sequentially. Consequently, decisions made on one affect the subsequent issues. Moreover, the sequence of issues is not logical. The future mission of RMP and the CHP role in approving funding of RMP proposals for the entire RMP programs are basically the questions that should be addressed initially since they are "end purposes". Other issues such as décentralization, funding, and local RMP organization, have meaning only once "ends" are decided upon. I therefore suggest that issues (1) and (7) be set into a Part A of the document to be decided upon before the other issues which I suggest should be grouped into a Part B, receive attention at all.

With respect to the particular issues we have the following comments:

Issue I: The Mission of RMP

No purpose is served by eliminating the program or confining its activity to control programs. Therefore, I opt for options within

Issue I that permit RMP to continue to serve as a mechanism between the public sector and the private health provider which undertakes any or all issues within that community that have been identified as needing attention by the provider community. Maximum flexibility in program initiative responsibility has to reside within the local provider community if we are in fact to achieve a mechanism that communicates between the public sector and the private health providers in the field. This is what RMP is uniquely able to do. Therefore we support those options within this issue that allow RMP to do this without in any way delimiting its role. This would include options 2, 4, and 5. The rationale for this recommendation would be that RMP would remain the unique national communications network with providers through which HEW can bring leverage to implement change. A flexible role is necessary if it is to carry out national priorities within the context of local needs. A drastic change at this time in RMP's authority or organizational structure would impede the progress we have made with the health care providers. At the same time that the authority remains flexible, increased emphasis can be given to RMP's role with respect to the closely related issues of manpower utilization and productivity and quality assurance. RMP can be an effective technical assistance tool in the quality assurance area and use an emphasis on manpower utilization and productivity to assure the implementation of quality assurance programs.

Issue VII: Relationship to CHP

The RMP program needs to be better tied to the CHP review process, particularly in light of the view that this is a local program. Our preference would be to have the RMP grant be subject to the CHP review and comment and have CHP approval of objectives of the grant rather than have them undertake the review and comment on specific activities proposed for within the grant. The exception to that rule would be that CHP should have review and approval over those activities included within the RMP program which would specifically result in construction of facilities, purchase of expensive equipment, payment for direct services, or other direct impacts on the delivery of services to people within the area. The RMP grantee should be held responsible to assure that the specific projects and activities funded through the RMP grant remain consistent with the RMP program which should have been cleared with a CHP agency.

In light of this, I would recommend a new option, 3, which would provide for review and approval by CHP on those RMP projects related to health care delivery systems improvement in the community, and for review and comment, but not veto authority on those RMP projects which are primarily developmental in nature, such as quality assurance activities, research

and development effort and general core support. The rationale for this recommendation would be that CHP should have approval authority over those projects which impact on the health care delivery system which is their primary concern. However, other projects which have a more generic nature and represent a demonstration or testing of approaches which might have more national rather than local applicability should not be subject to CHP veto authority. At the same time, the CHP should be given the authority to determine which projects fall into one or the other category.

Other Issues

Questions of decentralization and the methods of funding are really process issues. However, if you embrace the thesis that RMP is a device for us to communicate with the local provider community, then it ought to be basically constituted as providers with an advisory consumer activity. The funding mechanism which I feel most comfortable with would be an allowance to support the mechanism as a mechanism, with the ability to provide additional monies insofar as the local program reflects some nationally designated priorities. Special earmarks might be attached to reward RMP's which pursue special national goals.

Therefore on Issue II concerning decentralization of authority, we would recommend option 4 which would allow for determining national objectives at the Federal level, assigning CHP responsibility for determining the degree to which national objectives are being met in the various states, and assign to RMP a major implementing responsibility for realizing national objectives in accordance with CHP determination of relative needs. The rationale for this is that it is consistent with the position that RMP's represent the Department's principal communication mechanism with providers, and at the same time it clearly points up the relationship between RMP and CHP and is consistent with the separation of planning and implementing authorities.

With respect to Issue III on how funds should be apportioned to local RMP's, we would recommend option 6, i.e. using a combination formula-competitive basis. The rationale is that this option provides the best balance for distribution of funds. The formula basis would be used to provide the core support for RMP's, while the competitive basis should be on a program rather than a project basis for national funds. At the same time the projects proposed by RMP's would be subject to review by CHP's for consistency with local planning objectives and priorities.

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With respect to Issue IV regarding categories of people to be represented on the board, we would recommend option 5 to include providers and public representatives. The rationale is that this is essentially the existing pattern in most RMP's and gives recognition to the basic philosophy that the RMP's do represent the provider arm of the implementing authorities. To specify too many particular categories of representation on the board makes too inflexible a requirement. However, by stipulating that other than providers must be on the board using the broad term "public" assures that there are nonproviders in the decision-making capacity.

With respect to Issue V concerning requirements for consumer participation, we would recommend option 1, allowing for 20% participation. The 20% figure is consistent with the direction in which most RMP's are now moving. To increase it beyond 20% as a minimum requirement would compromise our position with the providers. However, a minimum requirement will assure that consumers are represented in the decision-making role.

On Issue VI regarding public hearings on RMP activities, we would recommend option 2 to require RMP's to hold public hearings on general objectives for proposed programs but not with respect to awards for individual projects. Alternatively, and consistent with the Secretary's decision on the implementing agency under special health revenue sharing, the public hearings could be held by CHP on RMP projects, rather than held by RMP itself. In any case, public hearings promote accountability on the part of the RMP and makes the role of RMP more visible and therefore it should be a requirement. However, it should relate to the general outline of proposed programs rather than a project by project basis since most of the projects may be of a technical nature and not subject to clarification through public hearings. Review of individual projects, particularly those relating to health care delivery systems, would be subject to review and comment by the local CHP agencies and their related hearings processes.

We would appreciate the opportunity to review the next draft of this paper, particularly in light of its use as an appeal to the Secretary's decision on special health revenue sharing. If you have any questions about our comments, please contact Mr. Gerald Riso or Ms. Beverlee Myers.

Frederick L. Stone
- for -
Vernon E. Wilson, M.D.