
E001216

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TO: | AGENCY | BLDG. | ROOM

Mr. Riso

Chuck -

☐ APPROVAL ☐ REVIEW ☐ PER CONVERSATION
☐ SIGNATURE ☐ NOTE AND SEE ME ☐ AS REQUESTED
☐ COMMENT ☐ NOTE AND RETURN ☐ NECESSARY ACTION
☐ FOR YOUR INFORMATION
☐ PREPARE REPLY FOR SIGNATURE OF

REMARKS:

You will find section on RMP (p.5-8) of interest.

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To
From Ms. Beverlee A. Myers

PHONE	BUILDING	ROOM
32630		17A-12

FORM HEW-30 REV. 11/55 ROUTE SLIP * GPO : 1972 O - 462-401

(P) = OASPE = P&E at HEW
(H) = OASHSA = DuVal (Mr. Health)

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFAI
OFFICE OF THE SECRETARY

TO : The Secretary
Through: OS/ES ____

DATE 8/4/72

FROM : Assistant Secretary for Planning and Evaluation

SUBJECT : Decision Papers on Health Planning and Revenue Sharing - ACTION MEMORANDUM

P has reviewed the decision papers on health planning and implementation and on health grant consolidation. The comments below are organized according to the concurrence summary which is attached.

Planning and Implementation

1A and 1B - Composition of CHP Councils

P has recommended in the first issue paper on planning that providers be required on the CHP councils, continuing the "partnership" philosophy of CHP to provide a mechanism through which providers and consumers can work together. We agree with H to enlarge the partnership to include elected representatives. However, P recommends that you maintain your previous decision that provider representation be required, although limited to 24% of total council membership.

1C - Hill-Burton Council

The basic issue here is how best to eliminate the Hill-Burton Councils. One way is to merge them with the implementing agencie Another way, and the one recommended by H and P in the previous issue paper, is to merge them with the CHP agencies. Five States have already effected such mergers, since they are not prohibited from doing so by either the CHP or Hill-Burton legislation. In view of the fact that implementing agencies have not yet been developed and because merger of Hill-Burton and CHP councils appears to be an obtainable objective, P recommends that you hold to your previous decision to merge these two councils rather than wait for enabling legislation for implementing agencies. However, the implementing staff functions should be placed in the implementing agency.

3E and 3F - CHP Review of VA and DoD Projects

P recommends that only community projects of VA and DoD be included in the CHP review. At a time in which we are attempting to strengthen CHP agencies, P feels that it would be unwise to burden them with responsibility for full review of all VA and DoD Projects. It should

also be realized that many VA and DoD activities provide services to individuals from areas other than those encompassed by the local CHP agency.

4A - Funding of Local CHP Agencies

P disagrees with the recommended authorization level of $60 million. The estimated overall need to fully implement CHP is about $120 million, as stated by H. An independent analysis funded through this office came to a similar estimate. The question, therefore, is whether we want to reach this level and how quickly we want to do it. P believes that with vigorous effort by HSMHA, full implementation of CHP can be achieved within the next three years. Authorization levels should, therefore, be either "such sums as may be required," or $100 million (about 80% of the total estimated need).

Two factors have been cited as retarding the implementation of CHP: (1) lack of trained manpower, and (2) administrative difficulties in organizing CHP agencies. P disagrees with H that 3,000 planners will be needed. Only a small number of trained "planners" are needed for each agency; most of the staff of CHP agencies are presently individuals who were trained in a variety of related disciplines, such as economics, statistics, business administration, and various health fields. Even if "planners" were desired exclusively, a recent survey by the Journal of the American Hospital Association identified approximately 4,500 individuals now receiving health planning education in U.S. universities. In addition, many others are receiving community planning education. A second factor in the rate of implementation is that of organizing the agencies. At present there are 194 CHP (b) agencies. Firm plans have been made for an additional 90 agencies in FY 1973. Some States are organizing these agencies without Federal funds at present in anticipation of future Federal support. Thus, at the end of FY 1973 only about 40 additional agencies will be required for full national coverage.

4B - Funding of State CHP Agencies

P concurs with the H recommended authorization level of $20 million for State agencies. Although no analysis was conducted in arriving at this figure, a rough estimate indicates that such a sum would "purchase" about 16 staff members for each of the 56 State and Territorial (a) agencies (at approximately $22,000 in total administrative costs per staff member). Given the greater financial resources of States as opposed to local areas, the States can and should supplement Federal funds sufficiently to add needed staff above this level.

4C and 4D - Consolidation of RMP and Hill-Burton Planning into CHP

P recommends that planning authority for RMP and Hill-Burton be specifically placed into CHP in order to clarify the relationships among these programs. However, rather than transferring funds, budgets can simply be adjusted by the proper amounts.

4F, 4G and 4I - Matching Level, Matching Funds and Human Services Planning

P agrees with the recommendation by H that the matching level be set at 80/20, that (b) agencies be allowed to use "clean" private funds (but not provider funds), and that States be encouraged to coordinate CHP with other planning agencies. However, we foresee a serious problem arising for some (b) agencies in obtaining the 20% matching share. Most (b) agencies are private, non-profit agencies which receive little public money. Few States have enacted enabling legislation for CHP.

In response to the encouragement of OMB Circular No. A-95, and in an attempt to coordinate planning agencies being established by several Federal programs (transportation, urban development, economic development, health, etc.), almost all States have established sub-State planning and development districts. A-95 requires Federal programs to observe those geographical areas. Some States have also established regional planning councils in those districts which serve as umbrella agencies for all the planning agencies. State tax funds are then provided to the planning agencies through the regional planning councils. P believes that coordination of planning and sharing of staff and facilities can best be accomplished through such umbrella agencies. Therefore, P recommends that model legislation be developed for States authorizing such regional planning councils and also providing State and local funding for CHP agencies through them.

As an alternative approach for funding health planning, P suggests that the possibility of a Federal tax on health insurance be explored. The costs which a community pays for health insurance is in proportion to the services it uses and the benefits it receives. One of the benefits of comprehensive health planning should eventually be to reduce or retard the growth of health costs. A mechanism for relating benefits to costs is to require a portion or all of the expenses of CHP to be paid by third party reimbursers, including Medicare and Medicaid. Such a tax, if used only for the 20% community share would amount to about 1/10 of one percent of premium charges. If all CHP costs were borne this way, the rate would be between 1/4 and 1/2 of one percent.

5A - Advisory Council

P disagrees with the H recommendation that the implementing agency have an advisory council rather than a policy board. We feel that the basic purpose here is to involve citizens both in decision-making and in aiding the implementation of projects. Advisory councils have not worked well in the past because the staff usually makes all the decisions, and the council serves simply as "window dressing." The CHP and RMP councils are both policy boards and both have been very successful in effecting citizen involvement; the councils actually make the decisions. Therefore, P recommends that the implementing agency have a policy board. Further, P recommends that the CHP statute be changed to specify that the councils be policy boards.

5B - Membership of Implementing Council

P disagrees with the H recommendation that the council of the implementing agency be required to have a majority of consumers and elected officials, although both of these groups should be represented. The purpose of implementing agency councils is to provide technical assistance in developing projects. Thus, it may be appropriate for a majority of the members to be providers. The CHP agencies will have a majority of consumers and will have approval authority over all projects of the implementing agency, so consumers will have effective control over providers in that way. (See further comments on 5D.)

5C - Public Hearing on Plan of Implementing Agency

P disagrees with the H recommendation that the implementing agency be required to hold public hearings on its plan. P recommends that the implementing agency hold no public hearings on either its plans or its specific projects, although its business certainly should be conducted in public. A public hearing on projects conducted by the implementing agency would effectively preclude the CHP agency from disapproving any project. Instead, P recommends that the CHP agency

hold public hearings on its plan and on specific projects as needed as part of its review and approval process.

5D - RMP as the Implementing Agency

P submits the following discussion of RMP for the Secretary's consideration.

Mission/Activities

Most of the major criticisms of RMP have not been with the administering mechanism itself nor even with the "revenue sharing" funding approach; instead they have been criticisms of the mission, of the activities supported by RMP's.

There are three basic questions concerning the mission of RMP:

1. What mission does the Department desire for RMP?

2. What mission is RMP capable of and willing to accept?

3. To what extent do these coincide?

The present mission of RMP is basically that of improving the quality of the provider/patient encounter. A number of subordinate questions arise concerning the continuation of that present mission or the possibility of an alternative one.

1. Is the present mission of RMP - that of supporting education and training programs for providers who are already employed - an appropriate use of Federal tax funds? Should providers be expected to provide high quality care without such incentives?

2. If Federal intervention is required to assure high quality care, is this form of intervention the most desirable? The RMP system relies entirely on voluntary participation. It offers no extrinsic rewards; it possesses no sanctions. Should the Federal government instead require performance review, in order to assure quality? H has indicated that RMP may be a useful instrument to undertake the role of utilization and performance review, since it is provider controlled but is more inclusive than medical societies. In their national meeting in St. Louis last January, however, RMP's strongly rejected this "policeman" role.

3. What results is the present RMP system really achieving in improving quality of care? Are adequate data available to provide significant measures of results, or are only anecdotal data available? Are those providers being reached who most need aid?

4. What priority does the present RMP mission merit compared with that of assuring access to any quality of health care for those who do not now receive it?

5. H has pointed out that RMP and CHP should be viewed together and that RMP might begin implementing the plans of CHP. Since CHP is mainly concerned with improving access - the distribution of health manpower, facilities, and services - should the mission of RMP be changed accordingly? To what extent would the RMP's be willing to accept this new mission?

6. As a result of various legislative and administrative decisions, several activities for improving the quality of care formerly supported only by RMP are now being supported by other HEW organizations. The Administration's new cancer and heart initiatives have placed quality improvement programs for those diseases into the respective institutes of NIH. Following enactment of the Administration's new health manpower legislation, the Department has placed responsibility for the development of general continuing education and upgrading training programs into BHME. Responsibility for developing AHEC's was also placed into BHME. Should the Department have several agencies supporting the same activities? Should support of these activities by RMP be terminated?

The RMP Administering Mechanism

1. H has pointed out that much time, effort, and money have been devoted in the past seven years in developing the RMP mechanism - the RAG's and the core staff. In 1972, approximately $44.4 million (about 40% of program funds) was used for support of the RMP mechanism; i.e., administrative costs and staff activities. Core staffs now average about 30 full-time equivalent positions, and staff salaries run as high as $45,000 per year. However, H has pointed out that the RAG's, not the core staff, form the linkages with the community. By comparison, CHP State agencies have an average staff size of about six.

How much money should the Department continue to provide to support the RMP mechanism? What size should core staffs be? Should salary levels be brought into line with those in the Federal government?

2. At present, RMP's are accountable to themselves and to RMPS in HSMHA. And yet, RMP is discussed as a form of revenue sharing.

   What is the desirability of a revenue sharing program which is not accountable to locally elected officials? What is the likelihood that the Administration or the Congress would propose to continue such a revenue sharing program?

Funding Mechanism

The funding mechanism used for RMP activities is basically a modified revenue sharing approach, although contracts and specific project grants are also used for certain activities. Some of the most visible accomplishments of RMP to date have resulted from activities supported by contracts or earmarked grants; e.g., the development of emergency medical systems projects and HMO project grants. True revenue sharing might place no restrictions on grant funds; however, the Administration's special revenue sharing programs all have some earmarks.

Should RMP basic grant funds be earmarked? Should the basic grant be used to implement CHP plans with additional activities, such as "monitorin quality," supported by earmarked funds?

RMP as an Implementing Agency

The basic purpose of an implementing agency is to provide the technical assistance necessary to develop projects. Simply publishing a request for proposals is not sufficient to implement a grant program. Someone has to provide assistance to communities to develop projects in response to those requests. Some of the clearest successes of RMP have been in providing such "implementing" assistance. RMP's have helped to develop projects for heart, cancer, stroke, and kidney disease care all over the nation. Both the Administration's Emergency Medical Systems Program and the RMP EMS program have been implemented through RMP's. And many other smaller health services delivery projects have been implemented through RMP, including ambulatory care projects amounting to $14.6 million in FY 1972. Thus, RMP has proved to be a very effective "implementing agency" in the past, although it has not acted as an implementor of CHP plans.

Recommendations for RMP

P makes the following recommendations for RMP:

1. The RMP mission should be changed to that of improving access to care, although additional activities might be supported through the RMP mechanism with the use of contracts or earmarked grants. One additional activity should be utilization/performance review of providers.

2. RMP should be made the implementing agency for CHP plans. Hence, RMP projects should be in accordance with and pursuant to the plans of CHP. In agreement with the Secretary's decision, CHP should review and approve projects of RMP. Activities of RMP's should be carefully monitored to assure that they do not undercut the planning efforts of CHP.

3. RMP should also be used to aid in implementing other service development programs of HEW. In addition to EMS and HMO, RMP could help to implement the Hill-Burton loan program, National Health Service Corps, CMHC's, Neighborhood Health Centers, Family Health Centers, etc.

4. Departmental support for education and training programs should be funded through BHME and should be limited to the development of programs; tuition charges should pay educational costs in full. Departmental support for cancer and heart activities should be funded only by NIH. RMP support of these activities should be terminated.

5. An analysis of desirable staffing levels and consequent funding levels of the RMP mechanisms themselves is needed. Staff and salary levels appear too high at present.

6. Since CHP will review and approve RMP projects, RMP's should be brought into conformance with State boundaries.

7. Until the new mission of RMP is clearly established, the RMP funding mechanism should not be revenue sharing. Instead its activities should be carefully monitored with earmarks applied where necessary.

Health Revenue Sharing

7A - Purpose of Health Grant Consolidation

The issue paper discusses four purposes of present grant programs (page 51). These same four purposes might be restated in the following way:

1. Financing of health services,
   a. Protection, prevention, and disease control services,
   b. Provision of health services for certain target groups.
2. Support of State and local health departments,
3. Development of new health planning and implementing agencies,
4. Development of new community health resources.

Each of the four categories of grants is discussed below, and the recommendations of P for a consolidated grant program are summarized.

1. Financing of Health Services

As indicated in the issue paper, there are basically two kinds of grant programs which pay for health services.

a. Protection, Prevention, and Disease Control: Formula and project grants in this category support what can be termed traditional public health activities. Included are the basic formula grants under section 314(d) and those activities funded under section 317 and 314(e) for communicable disease control, venereal disease, TB, rubella, rodent control, and lead based paint poisoning prevention. These grants are awarded to State and local health departments which usually provide the services directly. P recommends that these grants be included in grant consolidation.

b. Services for Particular Project Groups: P recommends that project and formula grants in this category which are presently made to State and local health departments for the direct provision of services in public health clinics be included in grant consolidation. Included are MCH formula grants and project grants for dental health for children.

On the other hand, P recommends that those grants which pay for services in private health care organizations not be included in grant consolidation. Since these services are similar to those provided directly through public health clinics, some States may decide to stop funding private projects and instead use the funds for public health services. P feels that the Federal government should avoid the expansion of the public provision of health services; instead, Federal funds should be used to subsidize the payment for services through the private sector. Our concern is not with who controls these programs, but who provides services. Rather than include these grants in grant consolidation, P recommends that they be maintained at the national level temporarily and terminated as national health insurance assumes payment for the services. Social and outreach services not covered by health insurance can be reimbursed through other financing mechanisms, such as Title IV-A. Included here are project grants which were originally intended as development projects but which are currently used primarily for financing services in centers already developed; e.g., M & I, C & Y, and 314(e) centers. Future project grant programs should be restricted tothe provision of seed money for the development of services and should not be used as services financing mechanisms.

2. Support of State and Local Health Departments

A portion of the Federal grants to State and local health departments for provision of services is also used to support the health departments themselves - staff salaries, administrative costs, etc. Thus, grants for the provision of services by health departments and support of health departments can be considered together.

3. Development of New Administering Mechanisms for Services Development

In the same way that health departments administer grants supporting the provision of services, the purpose of planning and implementing agencies is to administer services development activities. The development of planning agencies is underway, but many changes are required to improve their effectiveness. Your previous decision was not to include CHP grants in grant consolidation. As discussed above, P recommends that RMP be made implementing agencies but that they not be included in grant consolidation.

4. Development of New Community Health Resources

For reasons specific to each program, P recommends that services development programs not be included in grant consolidation. The reasons for not including RMP are given in 5D above. As discussed in item 8C below, P and H will be recommending to you in a separate analysis that Hill-Burton grants be eliminated. Inclusion of the HMO and Family Health Centers programs has not been discussed; the HMO program is new, and Family Health Centers are demonstration grants. Other programs, such as those for Neighborhood Health Centers and Community Mental Health Centers which were originally designed as service development programs but have since become mechanisms for Federally subsidizing health care are discussed above.

Summary

On the basis of the above, P recommends that the following programs be included in grant consolidation:

Formula Grants	Project Grants
314(d)	Dental Health for Children
MCH	Lead Paint Poisoning Prevention
Crippled Children	Communicable Disease
Alcoholism	314(e)
Family Planning	- Rodent Control
	- Rubella Vaccination
	- Venereal Disease
	- Tuberculosis Control
	- Community Health

Grants which P recommends not be included in grant consolidation are the following:

Formula Grants	Project Grants
Hill Burton	Children and Youth
	Maternal and Infant Care
	Migrant Health
	314(e) Centers
	CMHC
	Family Planning
	CHP
	RMP

7F - Maintenance of Effort

P disagrees with the recommendation of H that maintenance of effort be required. Such a requirement would penalize States which have put forth the greatest effort in health. In addition, such a requirement would be very difficult to administer. The Federal requirement on level of effort by the States can be considered to be the matching ratio of the grants. Finally, inflation would blur the impact of such a proviso over time.

8A - 314(e) Grants in Grant Consolidation

P recommends that all the activities now supported by 314(e) funds except health centers be included in grant consolidation. Consistent with the reasons given in 7A above, P recommends that grants for Neighborhood Health Centers and Family Health Centers not be included.

8B - Include RMP in Grant Consolidation

The recommendations of P for RMP are given in item 5D above.

8C - Include Hill-Burton in Grant Consolidation

P agrees with H that Hill-Burton grants should not be included in grant consolidation, but for different reasons. As mentioned in the rationale statement by H, an analysis of the Hill-Burton program is underway. In an issue paper being prepared for you, H and P will recommend that the Hill-Burton grant program be eliminated. Therefore, P recommends that it not be included in grant consolidation unless Congress refuses to go along with the request to terminate the grant portion of the program. You may prefer to withhold decision on this program until the issue paper is forwarded to you.

8D - Include Migrant Health Grants in Grant Consolidation.

For the reasons given by H, P agrees that migrant health grants should not be included in grant consolidation.

9A and 9B - Earmarks for MCH and Mental Health

P recommends that no earmarks be imposed unless a strong case can be made that the States will divert most of the funds to activities

not supported by the present programs. Present health department expenditures of State and local funds appear to coincide with Federally funded activities.

9C - Earmark for Innovation

In the first issue paper, P opposed an earmark for innovation, and our position is unchanged. It violates the principle of local determination, which is the essence of revenue sharing. It would generate administrative problems regarding what constitutes innovation and could result in ill-planned change. Innovations and demonstrations of national concern should be administered out of Washington through project grants.

/s/

Laurence E. Lynn, Jr.

PREPARED BY: CTAYLOR/DMcCLOUD:ASPE:8/14/72:x34204

Comments of P

	Agree	Disagree	Written Comments 1/
Health Planning and Implementation			
Health Councils			
1A. State Health Council		x	x
1B. Areawide Health Council		x	x
1C. Hill-Burton Council		x	x
1D. Training		x	
Agency Staffs			
2A. Salary	x		
2B. Merit System	x		
Scope of Review			
3A. Appeal to State	x		
3B. Appeal to Secretary		x	
3C. Manpower	x		
3D. OEO Projects	x		
3E. VA Projects			x
3F. DOD Projects			x
Funding			
4A. Local health planning		x	x
4B. State health planning	x		x
4C. RMP		x	x
4D. Hill-Burton		x	x
4E. Medicare	x		
4F. Matching level			x
4G. Matching funds			x
4H. Certificate-of-Need	x		
4I. Human Services Planning			x

Comments of P

	Agree	Disagree	Written Comments 1/
Implementing Agency			
5A. Advisory Council		x	x
5B. Membership of council		x	x
5C. Hearing		x	x
5D. RMP		x	x
Health Revenue Sharing (Grant Consolidation)			
6A. Future action			Abstain
General Principles			
7A. Purposes		x	x
7B. Elected officials	x		
7C. Formula	x		
7D. State plans		x	
7E. Matching	x		
7F. Maintenance of Effort		x	x
Funding			
8A. 314(e)		x	x
8B. RMP		x	
8C. Hill-Burton		x	x
8D. Migrant	x		
8E. Formula	x		
8F. Matching	x		
Program Emphases			
9A. MCH		x	x
9B. Mental Health		x	x
9C. Innovation		x	x
Structure of Legislation			
10A. Separate proposals	x		

1/ Please check if written comments on the item are presented.