
E001202

ISSUE PAPER

REGIONAL MEDICAL PROGRAMS

October 19, 1972

MEMORANDUM

OFFICE OF THE SECRETARY

DRAFT

October 19, 1972

TO : The Secretary
Through OS/ES

FROM : Assistant Secretary for Health and Scientific Affairs

SUBJECT: Decisions on Regional Medical Programs -
ACTION MEMORANDUM

This Action Memorandum develops alternatives for the future of RMPs and related RMP issues. It is supported by a Summary Memorandum (Tab A), and by considerable background material under Tab B.

ISSUES AND OPTIONS

A.
MISSION

ISSUE I. WHAT SHOULD BE THE PRIORITY FUTURE MISSION (ROLE) OF RMP?

OPTION 1. RMP should become a principal agency responsible for implementing change in local delivery system (implementing agencies for CHP and other HSMHA components, NIH, etc.).

DISCUSSION

Elimination of restrictions on interference with practice of medicine and of categorical emphasis are necessary to fulfill Option 1.

PRO: 1. Clearly separates planning from implementation.

2. Consistent with HSMHA's mission in delivery reform.

3. Gives it specificity without unnecessary restriction.

4. Has been successful in the past in implementing role.

CON: 1. Makes it hard to evaluate.

2. Difficult to provide Federal direction.

3. Proposal to eliminate categorical emphasis and restriction against "interference" with medical practice would be unpopular with AMA and other lobbying groups.

4. Dependent upon emergence of an effective local planning process.

5. Would impose an untested responsibility on RMPs in terms of relationship to CHP agencies.

6. Lack of broad representation on Board.

7. RMP has shown little interest in preventive health issues.

8. RMP has shown little interest in maternal and child health issues.

OPTION 2. RMP should continue as is -- flexible, variable, broad authority which encourages providers to use their own initiative to bring about change they support.

PRO: 1. Consistent with Departmental and HEW/HSMHA philosophy of decentralization and local initiative.

2. Allows flexibilities so that the program is able to meet local needs in a local manner.

3. Maintains flexibility for responding to changing national priorities.

4. Consistent with past practice which has achieved considerable professional and Congressional support.

CON: 1. May not be highly responsive to HEW priorities.

2. Evaluation is more complex when the program is investing in a variety of activiries.

3. Provides Federal support for some projects and reforms for which providers should bear the cost (e.g., continuing education of physicians).

4. No measurable nationwide effect.

OPTION 3. RMP should restrict its activities to "categorical areas" (heart, cancer, stroke, kidney).

PRO: 1. Political and professional constituency easy to identify and highly supportive.

2. Easier to account for expenditures.

3. Provides opportunity for working relationship between NIH research and control programs, and the HSMHA focus on delivery activities.

CON: 1. Tends to fragment delivery system - obstruct efforts to improve access.

2. Inconsistent with HEW position on limiting categorical approaches to solving problems.

3. [illegible] duplication of effort and funding with NIH.

OPTION 4. RMP should emphasize improving the utilization and productivity of manpower.

PRO: 1. Consistent with HEW philosophy of cost containment and delivery reform.

2. Progress in this area cannot be achieved without the input and involvement of providers.

3. Encourages a closer relationship between the production of health manpower and their actual performance or utilization, i.e., relationship between education and health services delivery.

CON: 1. Could be done well only with a consistent Federal health manpower strategy. Otherwise might produce scattered, inconsistent activities.

2. Creates resistance from educational institutions which regard this as their area of responsibility.

3. Creates bureaucratic turf problems a la AHEC's.

4. Proposed emphasis on "productivity" raises the question of whether we really know enough to accomplish this, and if we do, can we really capitalize on it -- manipulate the system enough to use it.

* OPTION 5. RMP should become the agency responsible for aiding local groups to organize and audit review activities aimed at assessing and assuring quality of care throughout the country.

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* NOTE: Options 5 and 6 may be heavily influenced by specific provisions in pending H.R. 1.

PRO: 1. Necessary to develop mechanisms for measuring quality that are workable and acceptable to providers and the community.

2. Necessary to provide corrective action in response to deficiencies identified by quality monitoring.

3. Only provider influenced groups will be effective in this area.

4. Efforts to develop peer review mechanisms require extensive resources and technical assistance to raise the level of understanding of quality monitoring, and start initial development at the State or community level.

5. National interest in developing quality assurance activities.

6. National need for technical assistance in quality assurance.

7. Consistent with professional interest in many RMP groups and staff.

CON: 1. Difficult to measure results.

2. The costs of this effort might better be borne by provider groups than HEW.

3. Local PSRO groups may not accept RMP involvement.

4. Many RMP's may resist assignment.

* OPTION 6. RMP should become agency responsible for monitoring quality of care.

PRO: 1. Federal need to take more positive leadership to provide an alternative to or implement PSROs and quality assurance mechanisms which completes the cycle of: (a) development of monitoring systems; (b) actual monitoring itself; and (c) corrective action in areas of identified deficiency.

2. All pro-arguments in Option 5.

3. The most appropriate existing institution which relates to a greater range of provider groups than just medical societies, as in PSROs.

CON: 1. Not all RMPs are equipped to handle this responsibility.

2. Raises the question of whether providers should dominate regulation of their own activities.

3. Monitoring or regulatory power would jeopardize relationship that RMPs have developed with providers.

4. Would probably limit RMP to that activity because RMP would occupy an antagonist role with provider colleagues.

5. Most RMPs would probably resist assignment.

OPTION 7. RMP should be eliminated completely.

PRO: 1. In times of budget stringency substantial money could be saved.

2. Provider dominated groups will not bring about major change in delivery system.

3. See criticisms of Program in Section of Tab B.

CON: 1. Has taken 5 years to develop a workable link between Federal Government and providers of care; this would be lost.

2. Provides a flexible implementing mechanism at the community level to work on problem areas.

3. May not be politically viable.

4. See Program Strengths in Section I of narrative.

OPTION 8. RMP should be eliminated as a Federal program; corresponding funds should be applied to health revenue sharing.

PRO: 1. The Secretary has made a preliminary decision to this effect.

2. In addition to the PSROs under Option 7, the revenue sharing approach is probably more acceptable, politically, than outright elimination of the program.

CON: 1. Has taken 5 years to develop a workable link between Federal Government and providers of care; this would be lost.

2. Provides a flexible implementing mechanism at the community level to work on problem areas.

3. May not be politically viable.

4. See Program Strengths in Section I of narrative.

RECOMMENDATION

Primary Mission

Secondary Mission

Not Recommended

RATIONALE

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COMMENTS AND SUGGESTIONS _____

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B.
DECENTRALIZATION AND FUNDING

ISSUE II. GIVEN H's RECOMMENDATIONS AS TO RMP MISSION, WHAT SHOULD BE THE EXTENT OF DECENTRALIZATION OF AUTHORITY TO THE LOCAL RMPs?

DISCUSSION

This issue is closely related to ISSUE I - MISSION.

OPTION 1. Complete local authority.

PRO: 1. Most nearly consistent with Administration philosophy of decentralization, State responsibility, and local initiative.

2. Most acceptable to the RMPs and providers.

3. Most compatible with relating to local needs, objectives, and resources, and resultant local variations in approach and priorities as determined by CHP.

CON: 1. May not address priorities set by identified RMP mission.

2. In face of funding constraints and possible cutbacks, it is unreasonable to expect rapid reorientation in line with new mission in absence of Federal direction.

3. May have little impact on national objectives.

OPTION 2. Partial, with local RMPs having latitude to pursue specific proposals within the broad priority areas as established by their redefined mission and local CHP plans.

PRO: 1. Still reasonably consistent with Administration philosophy of decentralization.

2. Compatible with relating to local needs, variations, and CHP planning.

3. Helps assure that RMP activities will address broad national priorities.

CON: 1. Would not be as acceptable to RMPs and providers as Option 1.

2. Would not necessarily insure that all local RMPs would adequately address each of the several broad priority areas, e.g., monitoring of quality of care.

OPTION 3. Minimum decentralization -- discretion re best methods of carrying out a strong Federal directive.

PRO: 1. Would most nearly insure that local RMPs address broad priorities.

2. Important in achieving missions which warrant continuing support of RMP.

CON: 1. Totally inconsistent with HEW decentralization philosophy of local initiative to meet local problems.

2. Unlikely that providers would willingly accept such strong direction.

3. Runs counter to actual long-term trend of increasing decentralization to local RMPs.

OPTION 4. Determine national objectives at the Federal level; assign to 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.

PRO: 1. To make a decentralized system accomplish national objectives. There must be a clear articulation of these objectives; the CHP agency is the appropriate mechanism for evaluating State and local circumstances and problems in the light of national objectives.

2. The capabilities of RMP will be most effectively used through supporting the achievement of such objectives, and catalyzing the provider sector in that direction.

CON: 1. The concept of health revenue sharing and decentralization is to recognize State and local objectives which may be different from national objectives.

2. A structure such as that proposed in this Option would so limit RMP that provider interest and support would be lost.

RECOMMENDATION

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ISSUE III. HOW SHOULD FUNDS BE APPORTIONED/DISTRIBUTED TO THE LOCAL RMPs?

OPTION 1. Competitive project basis.

PRO: 1. Improves review of individual proposals against priorities.

2. Allows better coordination of related activities; helps minimize unnecessary duplication of effort.

3. Minimize local patronage and bias.

CON: 1. Administratively cumbersome and costly HEW role.

2. Unlikely to correlate funding with local needs and problems as there would be a tendency for those RMPs and sponsoring institutions (e.g. medical schools) most proficient in grantsmanship and with the greater resources to obtain a larger share of the funds.

3. Would not utilize the considerable local technical review and decision-making capacity and structure that has been created by the RMPs over the past six years.

OPTION 2. Competitive program basis.

PRO: 1. Would provide better incentives for RMPs to address priorities.

2. Would encourage a high level of competition and, thus, qualitatively better activities.

3. Would help overcome the criticisms (CONs) of Option 1.

CON: 1. Would reduce flexibility once programs approved; RMPs would tend not to be as fully and rapidly responsive to possible changes in priorities.

2. Would tend to reward stronger RMPs and not weaker ones.

OPTION 3. Competitive basis with selected earmarks.

PRO: 1. Earmarks would provide incentives needed to spur local RMPs to engage in activities addressing high but less popular priorities (e.g., quality of care monitoring) that many of them otherwise might be reluctant to undertake.

2. Closely coincides with present mode.

3. Offers advantages similar to Option 2.

CON: 1. Earmarking, once resorted to, sets a precedent for further earmarkings; at the same time it is difficult to get rid of previous earmarks even though they have outlined their usefulness.

2. Disadvantages similar to Option 2.

OPTION 4. Use a formula basis.

PRO: 1. Consistent with HEW position on local initiative.

2. Provides local RMPs with significant flexibility.

3. More nearly results in an equitable distribution of funds to all RMPs.

CON: 1. Little or no incentive to use funds to address national priorities.

2. Difficult to develop a formula adequately taking into account potential resources and needs in various specific priority areas that would be equitable to all States.

OPTION 5. On a formula basis with selected earmarks.

PRO: 1. Would allocate specified sums for special priorities.

2. Provides fiscal equity to all areas.

3. Would require RMPs to develop proposals within each earmarked area, even if that resulted in funding some weaker projects in one given priority area at the expense of additional stronger projects in another.

CON: 1. Earmarking, once resorted to, sets a precedent for further earmarks; at the same time it is difficult to get rid of earlier earmarks that have outlined their usefulness.

OPTION 6. Use a combination formula-competitive basis.

PRO: 1. Provides a financial base for long-term commitment to professional staff.

2. Provides for competition.

CON: 1. May have programs sending stronger projects for competition and funding weaker nonpriority projects out of the formula.

RECOMMENDATION

RATIONALE

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COMMENTS AND SUGGESTIONS _____

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C.

ORGANIZATION OF LOCAL RMP UNIT

ISSUE IV. FROM WHAT CATEGORIES OF PEOPLE SHOULD THE LAW REQUIRE REPRESENTATION ON THE BOARD?

OPTION 1. Providers, consumers, elected officials, low income consumers, third parties, and CHP.

PRO: 1. Encourages well rounded board composition.

CON: 1. May be too restrictive to be practical in all the areas.

2. Providers may feel under-represented.

OPTION 2. Providers, consumers, elected officials, low income consumers. (Eliminates from Option 1 third party and CHP representation.)

PRO: 1. Third party and consumer representation are redundant.

2. CHP representation on board is not necessary if they review and comment on, or review and approve RMP projects.

CON: 1. Third parties and CHP provide different perspectives on problem areas and priorities that need to be addressed by RMP.

OPTION 3. Providers, consumers, elected officials, and CHP. (This Option eliminates designation of low income consumers from Option 2.)

PRO: 1. Provides more flexibility for organizing boards.

CON: 1. Low income consumers often experience different types of problems than do other consumers and therefore might provide a good balance to the board.

OPTION 4. Providers, consumers, and low income consumers. (This Option deletes specific mention of elected officials from Option 2.)

PRO: 1. More flexible than Option 2, and allows for elected officials under "consumer" designation, without specifically mentioning them.

CON: 1. Elected officials often are an important source of support for the program as well as sensitive to local issues and pressures.

OPTION 5. Providers and public representatives.

PRO: 1. Most flexible.

2. Permits each State to put together most effective group for their own particular area.

CON: 1. May not assure broad representation of relevant interests.

RECOMMENDATION

RATIONALE

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COMMENTS AND SUGGESTIONS _____

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ISSUE V. SHOULD THE POLICY BOARD HAVE A MINIMUM REQUIREMENT CONSUMER PARTICIPATION?

OPTION 1. Yes (20 percent)

PRO: 1. Shows a clear commitment by the Department to consumer representation.

CON: 1. Reduces flexibility; may not be necessary.

2. May be useless tokenism.

OPTION 2. Yes (33 1/3 percent)

PRO: 1. Shows a stronger commitment to meaningful consumer participation and involvement in decision making.

CON: 1. Same as CON 1, Option 1.

OPTION 3. Yes (51 percent)

PRO: 1. Shows strong commitment to consumer representation.

CON: 1. Same as CON 1, Option 1.

2. May harm relationships with providers and undo what RMP has developed over the past five years.

OPTION 4. No requirement.

PRO: 1. Most flexibility

2. Do not have to address this issue at this time.

CON: 1. Discredits HEW commitment to consumer participation.

RECOMMENDATION

RATIONALE

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COMMENTS AND SUGGESTIONS _____

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ISSUE VI. SHOULD THE LAW REQUIRE RMP TO HOLD PUBLIC HEARINGS ON PROPOSED RMP ACTIVITIES?

OPTION 1. Require RMP to hold public hearings in advance of approving proposed projects.

PRO: 1. This would provide an opportunity for effective public involvement.

CON: 1. This would unnecessarily duplicate existing reviews.

2. CHP should provide the primary form for public comment on proposed governmentally financed activities in the health care field.

3. Public hearings directed to the review of individual projects would be unduly cumbersome.

OPTION 2. Require RMP to hold public hearings on a general outline of proposed programs but not with respect to awards for individual projects.

PRO: 1. Provides appropriate opportunity for public input in a simpler and more expeditious manner.

CON: 1. Hearings of this sort would be too abstract to be effective.

2. See CONs under Option 1.

OPTION 3. Authorize but do not require public hearings.

PRO: 1. This would permit RMPs to tailor the use of the public hearing process appropriately to the nature of the issues that are under consideration.

CON: 1. If left optional, the public hearing process would probably rarely be utilized.

RECOMMENDATION

RATIONALE

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COMMENTS AND SUGGESTIONS _____

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ISSUE VII. SHOULD RMP LEGISLATION REQUIRE CHP APPROVAL AS A PRECONDITION FOR FUNDING RMP PROPOSALS?

OPTION 1. Require CHP approval.

PRO: 1. Strengthen CHP.

2. Establishes planning as a precondition for, and controller of implementation.

3. Reasonably assures that Federal money will not be used in a manner incompatible with other relevant programs.

CON: 1. Heavily restricts the provider role; may be unacceptable to providers.

2. CHPs are not qualified, technically, to control provider-sponsored projects not to respond in a timely fashion; therefore, this would not be a realistic requirement.

OPTION 2. Provide for review and comment, but not for an approval (i.e., veto) authority.

PRO: 1. Less restrictive and, hence, more acceptable.

2. CHP should, at a minimum, have a review and comment role.

CON: 1. CHP should have a stronger role than mere review and comment.

2. There is really no very compelling reasons for CHP to be involved at all.

RECOMMENDATION · [illegible] approval for Delivery charge
· [illegible] technical cost a limited
[illegible] [illegible]

RATIONALE

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COMMENTS AND SUGGESTIONS ______________________________

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