Jennifer

FYI.

Marilyn

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH
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FAX 202-296-1252

March 21, 1995

FAX MEMORANDUM

TO: Marylin Yager (Fax # 456-6682)

FROM: Mike Gemmell

RE: White House Briefing

First, thanks for arranging a very impressive briefing for our deans last Thursday. The participation of senior Presidential advisors (Erskine Bowles, Carol Rasco, Chris Jennings and Barry Clendenin) in the meeting was greatly appreciated. The "surprise" entrance by Dr. Foster added a great deal to the event.

As promised, please find attached:

- memo to Dr. Rice (Sen. Kennedy) outlining our recommendations regarding amendments to Sen. Kassebaum's bill to re-authorize PHS health professions education programs (S.555)

- fact sheet regarding a proposal to tap Medicare GME funds for the training of preventive medicine residents, public health physicians and nurses

I would appreciate your sharing this memo with Barry Clendenin. He's been most helpful over the years on programs/issues of concern to our association.

Again, thanks for arranging such a terrific briefing last Thursday.

And thanks for your work in ensuring that the President signed the public health week proclamation. Well done. (And thanks for the 30 copies to send to the ASPH deans).

MKG/hsc

Graduate Public Health Education

The Key to Health Care Cost Containment, Outcomes and Quality

"In the 1950's and 1960's, there was general concern that the Nation did not have enough physicians to serve the public. During this period, hospitals bore the cost of educating physicians, providing residents with small salaries, plus room and board. When the Medicare program was established, the Congress believed that educational programs contributed to the quality of care and were necessary to meet community needs for trained personnel." (OIG, 1994). Medicare's stated purpose for supporting graduate medical education is to meet community needs for trained health personnel, which is defined in Medicare regulations as "medical interns and residents" and "nursing and paramedical personnel."

If Medicare's stated purpose for supporting GME is to meet community needs for "trained health personnel," and this personnel by definition includes public health practitioners, then Medicare GME should also support the training of these practitioners. While Medicare GME funds are well known for supporting the training of medical interns and residents, Medicare GME funds also support the training of dentists, nurses, cytotechnologists, dietitians, medical record librarians, medical technologists, occupational and physical therapists, radiology technicians, inhalation therapists, hospital administrators, and other health professionals (Medicare regulations, Chapter 4, Sec. 404).

Medicare indirect and direct graduate medical education payments are substantial sources of income for teaching hospitals and are estimated to reach $5.85 billion in federal fiscal year 1994. $1.75 billion pays for direct medical education costs (resident's salary and benefits, faculty supervision, costs, allocated overhead costs, and other costs). $210 million of this $1.75 billion (12.0%) is direct medical education reimbursement for non-physician training.

The existing system of Medicare and other payers directly subsidizing the costs of training of medical practitioners (especially medical and surgical subspecialists) and making payments only to tertiary teaching hospitals, means that Medicare GME is partially financing the training of the most expensive health care providers in the community. Policymakers and educators have already identified the need to train less specialists and more generalists. This proposal extends this concept one step further, training public health practitioners that can help bring prevention, outcome-oriented care, and care of special populations into managed care systems.

It is time to recognize that the imbalance of supporting the training of medical care personnel and not public health personnel is directly related to the high cost of health care and its expensive curative focus.

It is time that Medicare GME funds go beyond supporting only the medical care part of the U.S. health care system and begin supporting GPHE (Graduate Public Health Education) for the prevention-focused public health part as well.

GRADUATE MEDICAL EDUCATION
GRADUATE PUBLIC HEALTH EDUCATION

Teaching Hospitals vs. Teaching Public Health Departments

Medical vs. Public Health Training

Primary Functions	Clinical Practice	Public Health Practice
Research, Education, Service	Schools of Medicine, Nursing, Etc.	Schools of Public Health
Service, Education, Research	[redacted]	Teaching PH Departments
Service	Health Care Practice	Public Health Practice
[redacted]	[redacted]	GPHE Proposed

Approaches:

Administrative

- Amend regulations to have HCFA confirm that the costs of training graduate public health trainees are allowable (only teaching hospitals eligible without legislative change).

Legislative (SSA, Title XVIII, Sec. 1866 ff)

- Allow public health departments to be reimbursed for GPHE.
- Allow schools of public health to be reimbursed for GPHE.
- Allow consortia that include SPH and PH departments to be reimbursed for GME and GPHE.
- HCFA Demonstration grants.

Prepared by Darryl Leong, M.D., M.P.H.
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February 23, 1995 Regalwood Ave #4308, Burtsonville MD 20866 301-549-1595, 301-549-1583(FAX)
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March 17, 1995

MEMORANDUM

TO: Roselyn Rice
Fax 224-3533

FROM: Mike Gemmell

RE: Amendments to "Kassebaum" health professions bill

First, thank you so much for briefing/advising the deans on the status of re-authorization of health professions education programs, in general and on possible public health provisions, in particular. You were most helpful and very insightful as well.

The purpose of this memo is to solicit your assistance (and Sen. Kennedy's) in amending the proposed Kassebaum health professions re-authorization proposal along the following lines:

> **Sec. 102** Training in Primary Health Care, Preventive Medicine **and Public Health**. Public health training funds, for "departments" (read schools) of public health are needed to address the critical shortage of public health professionals (see "Eighth Report to Congress on the Status of Health Personnel," HHS). In fact, the term "public health" should be added throughout Sec. 102. And, schools of public health should be added to the "eligible entities" under this section.
>
> **On page 9, line 25 add:**
>
> (F) to provide special projects to schools of public health to expand and strengthen educational programs in disease prevention and health promotion.

In addition, we recommend that all titles and sections of the bill, especially the one entitled "minority and disadvantaged training," be authorized with such sums as necessary through FY1999.

Your thoughtful consideration of our requests would be appreciated.

MKG/mlw

March 21, 1995

Honorable Donna Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

The undersigned organizations, representing approximately 250,000 primary care physicians and medical specialists, are writing to urge you to recommend and implement changes in the Medicare fee schedule volume performance standards (VPSs) and update formulae to correct payment inequities that are undermining--even destroying--the intent of the resource based relative value scale (RBRVS).

In 1990, Congress mandated that HHS determine the volume performance standards for each category of services based upon five year volume trends for each category, respectively. HHS has continued, however, to use a common "all services" baseline in calculating the VPSs for each category of services. Although we understand that HHS initially did not implement this change because it did not have the data to track expenditures separately for each category, it is our understanding that such data were available and could have been used for the FY 1995 VPS calculations, and possibly for the FY 1994 VPSs. The Physician Payment Review Commission recommended last year that HHS use separate volume data for each category of services, and proposed VPSs based on the separate trends for each category. HHS declined, however, to accept this recommendation. Further, the PPRC recommended that Congress enact an update for 1995 that reflected what would have occurred had the FY 1992 and 1993 VPS been based on separate volume trends for each category. The administration did not support this recommendation.

According to the PPRC, use of a common volume baseline has resulted in significantly higher updates in the conversion factors for surgical procedures, and lower updates for primary care services and other nonsurgical services, than would have been the case had category-specific volume trends been used as required by OBRA 90. This has also magnified the distortions and inequities created by having separate updates and conversion factors for each category. The PPRC projects that continued use of a common volume baseline will result in the 1997 conversion factor for surgical procedures being 26.5 percent higher than primary care services and 29 percent higher than "other nonsurgical" services.

In the past, HHS has expressed its belief that OBRA 90 gave the Department the option of using either a common volume baseline or separate baselines for each category of service. We do not believe that is a correct reading of the statute. The PPRC agrees with us that OBRA 90 required use of separate volume baselines for each respective category of service. The common volume baseline can only be used to determine the "all services" VPS, which has no practical bearing on the updates for each category of service.

We believe that the agency must take steps now to bring the conversion factors back to where they should have been had the requirements of the law been followed. We specifically recommend that HHS:

1. Publish a notice in the Federal Register that corrects the FY 1995 VPSs by recalculating them based on separate volume trends for each category of services, as required by OBRA 90. Since the FY 1995 VPSs were announced only three months ago, there is still time to make this correction before too much of the fiscal year h passed.

We do not believe that HHS needs congressional approval to make this change, since OBRA 90 not only gives HHS the authority to base the VPSs on volume trends for each respective category, but requires that you do so.

#1 Priority move to single conversion factor

2. Calculate the FY 1996 default VPSs based on separate volume trends for each category. Since this would follow the requirements of OBRA 90, we do not believe that this change requires congressional action or publication of a proposed rule.

3. In the department's upcoming report to Congress, due on April 15, provide calculations on what the conversion factors for CY 1996 would have been had the VPSs for FY 1993 and 1994 been based on separate volume trends for each category of service. HHS should propose an update for calendar year 1996 that results in the conversion factors being equal to what would have occurred had the OBRA 90 requirements been followed. Now that historical data on volume trends within each category are available, it is incumbent on the administration to propose changes that bring the conversion factors to the level that were intended when Congress enacted the OBRA 90 requirements. It must be noted that these changes will not recoup the losses incurred by physicians who were underpaid for their primary care and other nonsurgical services for the past two calendar years.

We cannot stress more how important it is that HHS take steps to correct the inequities created by its practice of calculating the VPSs in a way that is in conflict with OBRA 90. The errors made in calculating the VPSs are destroying most of the shift toward primary care services intended under the RBRVS, and have unfairly reduced payments for other nonsurgical services as well. There is no justification for not taking steps now to correct those mistakes.

Finally, we welcome the opportunity to meet with you and/or HCFA administrator Bruce Vladek to discuss our concerns and recommendations in more depth.

Sincerely,

American Academy of Allergy, Asthma, and Immunology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Association of Clinical Endocrinologists
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Physicians
American College of Preventive Medicine
American College of Rheumatology
American Gastroenterological Association
American Geriatrics Society
American Medical Directors Association
American Osteopathic Association
American Society for Gastrointestinal Endoscopy
American Society of Clinical Oncology
American Society of Hematology
American Society of Internal Medicine
Infectious Disease Society of America
Joint Council of Allergy and Immunology
Renal Physicians Association
Society of General Internal Medicine

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Formerly The American Fertility Society

February 1, 1995

Ms. Jennifer Klein
Senior Policy Analyst
Domestic Policy Council
Office of the First Lady
Second Floor, West
The White House
Washington, DC 20500

Dear Jennifer:

Thanks for meeting today with those of us representing the Sexually Transmitted Disease Coalition. I wanted to follow up with the data I promised to give you regarding STDs and dollars saved by their early detection and treatment.

As we indicated during the meeting, statistics on rising STD rates are quite compelling by themselves. The cost savings on screening and early treatment speak volumes as well: $12 was saved on every $1 spent on prevention and treatment. I hope the attached information convinces you, and Mrs. Clinton of course, that this is a worthy public health initiative which has tangible results.

The information was compiled by the Centers for Disease Control and Prevention. What I'm sending you contains the nuts and bolts of a talk I heard last October by CDC Epidemiologist Susan Hillis. She works for Judy Wasserheit, who directs the CDC's Division of STD/HIV Prevention in Atlanta. If you're interested, I think Ms. Hillis would make an excellent contact. You can reach her at 404-639-8368.

You might recall meeting representatives of the American Society for Reproductive Medicine last year at about this time. We were still known as the American Fertility Society then, and you were very receptive to our attempts to get health insurance coverage for in vitro fertilization. We were grateful for your attention and commitment at that time, and we hope we can depend on your support of the STD issue now.

Thank you again for taking the time to meet with me and my colleagues. If you have any questions or need more information, please do not hesitate to contact me at 202-863-2494.

Sincerely,

Lisa Angerame
Policy Analyst

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